

# Choosing and using your plan

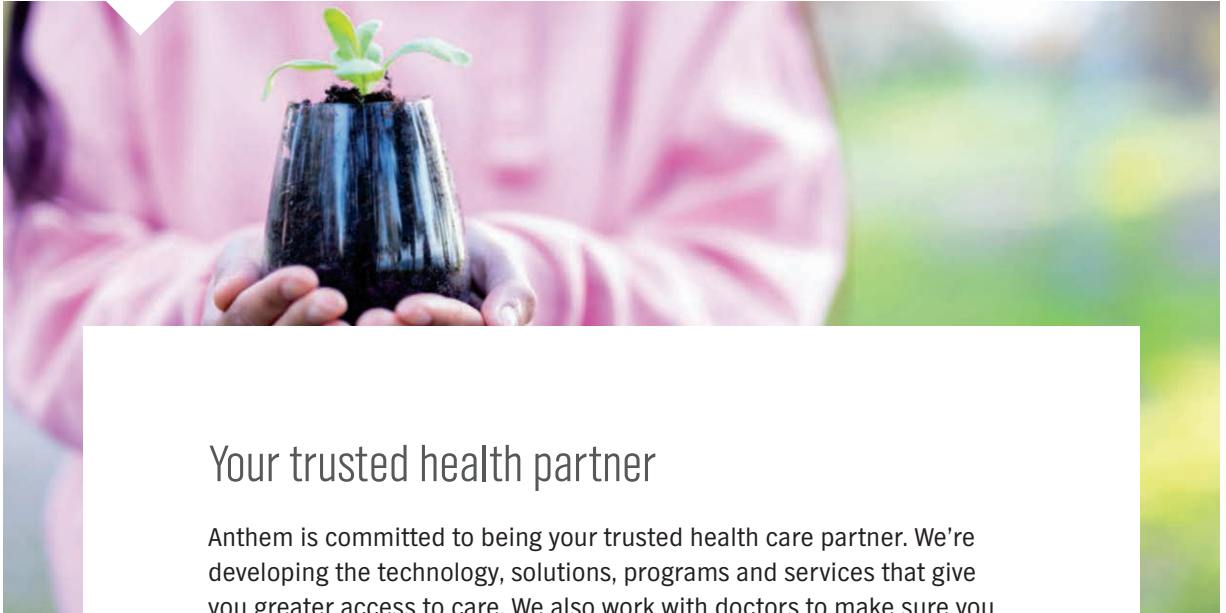
Your guide to open enrollment and  
making the most of your benefits



PPO Plan 4 and PPO Plan 7  
Virginia Private Colleges Benefits Consortium: Hampden-Sydney College  
Effective January 1, 2020



## It's time to choose your plan



### Your trusted health partner

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

### Save this guide

You'll find tips on how to make the most of your benefits and save on health care costs throughout the year.





# It's time to choose your plan

## Let's get started

This is the perfect time to think about your health — where you are right now and where you want to be tomorrow. It's your opportunity to check out the benefits, programs and resources that can support your health and well-being all year long.

This guide will help you understand our plans. It's also full of tips, tools and resources that can help you reach your health and wellness goals when you become a member. So keep it handy to make the most of your benefits throughout the year.



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## How to Enroll

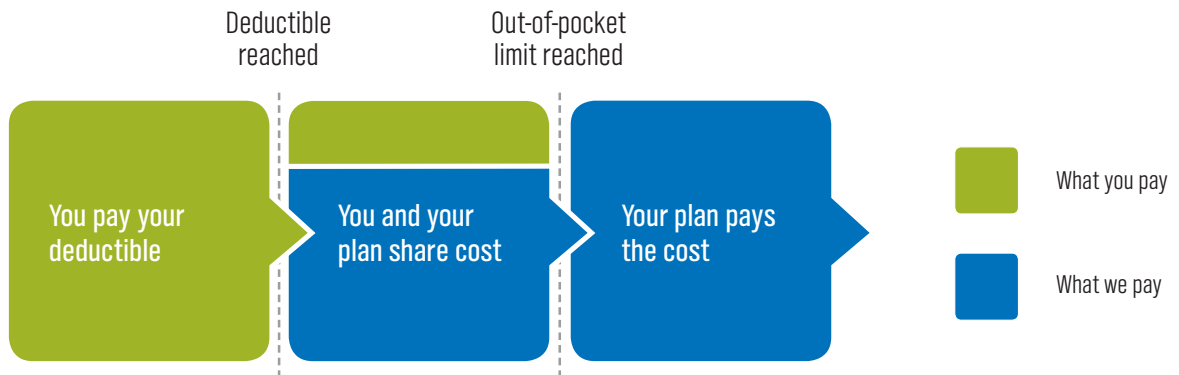


# The basics explained

Before we dive into the plan details, it may be helpful to review some health benefit basics.



## What you pay and what your plan pays



This chart is only an example. Your actual cost share will depend on your plan, the service you get and the doctor you choose. Check your plan details to see your actual share of the cost.



## Words that are helpful to know

We can help you crack the code of health insurance lingo. Here are the meanings of some common terms:

<p><b>Deductible:</b></p> <p>A set amount you pay each year for covered services before your plan starts to pay for covered health care costs.</p>	<p><b>Copay:</b></p> <p>A flat fee you pay for covered services like doctor visits.</p>	<p><b>Coinsurance:</b></p> <p>Once you've met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you'll pay.</p>
<p><b>Out-of-pocket limit:</b></p> <p>This is the most you have to pay out of your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. And some plans may still have you pay a copay at the time of service.</p>	<p><b>Premium:</b></p> <p>The premium, also called a monthly payment, is what you pay for the plan. It's the money that comes out of your paycheck. Think of it like a membership fee that's separate from what you pay when you get care.</p>	



## Vision benefits

When you choose Blue View Vision<sup>SM</sup>, you'll be covered for checkups and eye exams and you'll get allowances for the glasses or contacts you rely on.

Blue View Vision gives you access to more than 38,000 eye doctors at more than 27,000 locations across the country so you can find eye care and eyewear close to home and work. Locations include retail stores like LensCrafters®, Sears Optical®, Target Optical®, JCPenney® Optical and most Pearle Vision® stores. You can order glasses and contacts online through **Glasses.com**, **ContactsDirect** or **1-800-CONTACTS**.

Your vision benefits cover:

- Adult routine eye exams.
- Routine pediatric eye exams.

Blue View Vision's International Travel Solution helps you when traveling outside of the U.S.:

- Find a trusted eye doctor in 20 countries and territories.<sup>1</sup>
- Get 24/7 phone support with translation services in 160 languages.

- If you lose or break your glasses, you can get temporary emergency glasses with adjustable lenses delivered within 24 hours in most locations at no additional cost.

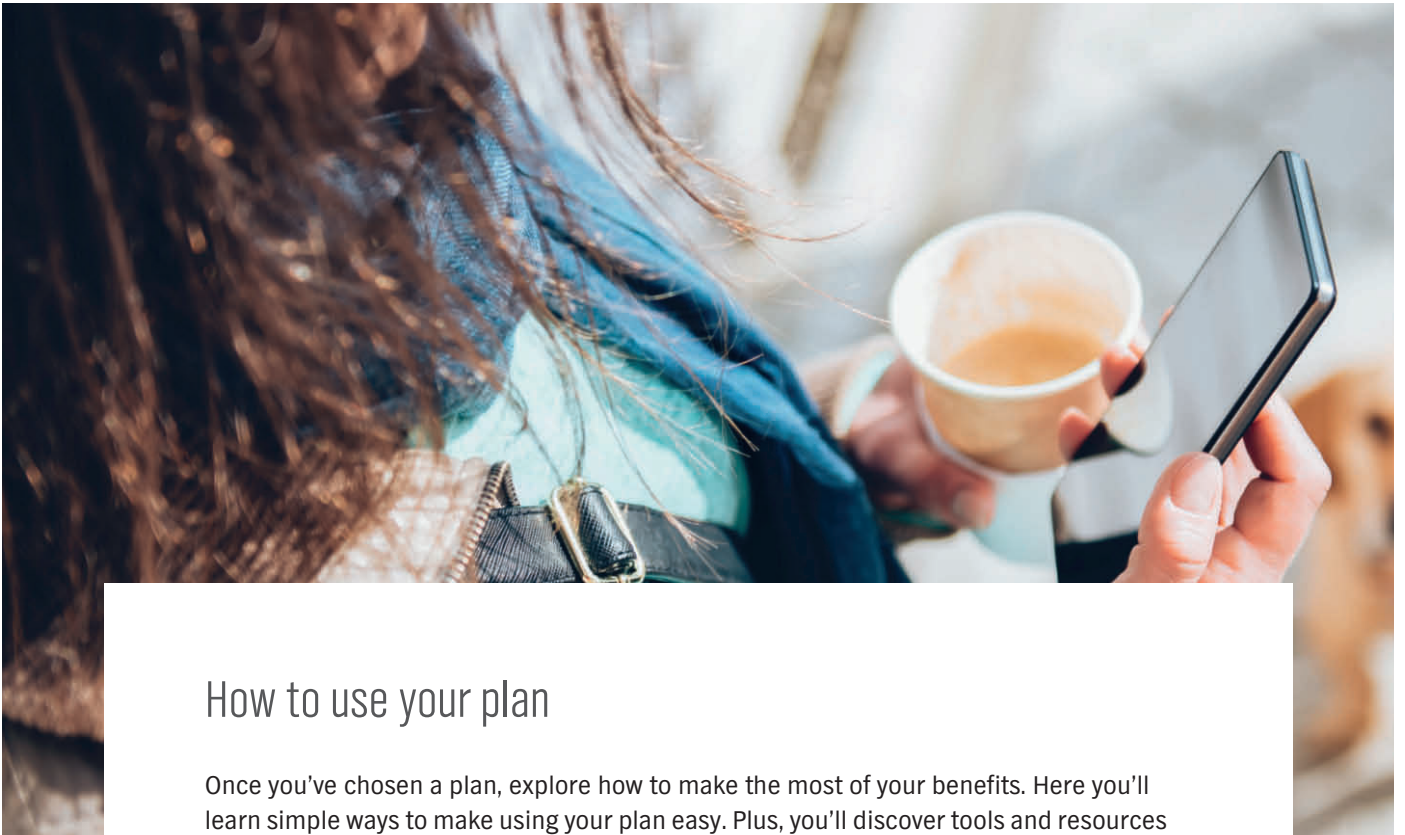
### Keep an eye on your health

Routine eye checkups go beyond making sure you can see clearly. They also can catch other health problems early, like diabetes, high blood pressure, high cholesterol and rheumatoid arthritis.<sup>2</sup>



<sup>1</sup> Available in Australia, Austria, Brazil, Canada, Chile, China, Colombia, Ecuador, England, France, Germany, Hong Kong SAR, Italy, Japan, Mexico, New Zealand, Peru, Puerto Rico, U.S., Spain and Switzerland.

<sup>2</sup> American Optometric Association website, *Evidence-Based Clinical Practice Guideline, Comprehensive Adult Eye and Vision Examination 2015* (accessed February 2019): aoa.org.



### How to use your plan

Once you've chosen a plan, explore how to make the most of your benefits. Here you'll learn simple ways to make using your plan easy. Plus, you'll discover tools and resources that can help you reach your health and wellness goals. With Anthem, supporting your healthiest self is all part of the plan!



## How to use your plan

### Use your ID card right from your phone

Introducing the **Sydney** mobile app. With **Sydney** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor. You can even use **Sydney** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney** mobile app.

### Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes life so much easier. Register on the **Sydney** mobile app and **anthem.com** to get personalized information about your health plan and more. You can:

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- View your claims, see what's covered and what you may owe for care.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.



## How to use your plan

### Find a doctor in your plan

The right doctor can make all the difference – and choosing one in your plan can save you money, too. So you'll be happy to know your plan includes lots of top-notch doctors. If you decide to get care from doctors outside the plan, it'll cost you more and your care might not be covered at all.

It's easy to find a doctor in your plan. Simply use the **Find a Doctor** tool on the **Sydney** mobile app or at **anthem.com** to search for doctors, hospitals, labs and other health care professionals.

### Schedule a checkup

Preventive care, like regular checkups and screenings, can help you avoid health problems down the road. Your plan covers these services at little or no extra cost when you see a doctor in your plan:

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

Check your plan details on the **Sydney** mobile app or **anthem.com** to confirm what preventive care is covered.





## How to use your plan

### See a doctor from home

You can have a video visit with a doctor using your mobile phone, tablet or computer with a webcam, whether you're at home, at work or on the go. Doctors are available around the clock for advice, treatment and prescriptions.<sup>1</sup> Just go to **livehealthonline.com** or download the LiveHealth Online mobile app to get started.

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

When it's an emergency, call 911 or head to the nearest emergency room.

But when you need nonemergency care right away:

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care – and avoid costly emergency room visits and long wait times.
- See a doctor anytime using LiveHealth Online. It works on your mobile phone, tablet or computer with a webcam.
- Call the 24/7 NurseLine and get helpful advice from a registered nurse.



<sup>1</sup> Online prescribing only when appropriate based on physician judgment. LiveHealth Online is the trade name of Health Management Corporation.



# Plan extras that support your health

Learn more by registering on the **Sydney** mobile app or at **anthem.com**.

Your plan comes with great tools and programs to help you reach your health goals and save money on health products and services. Plus, most of them come at no extra cost. Learn more by registering on the **Sydney** app or at **anthem.com**.

## Apps

Introducing the **Sydney** mobile app. With **Sydney** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor. You can even use **Sydney** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney** mobile app.

## Where to get care

**24/7 NurseLine** – You can connect with a registered nurse who'll answer your health questions wherever you are – anytime, day or night. They can help you decide where to go for care and find providers in your area. All you have to do is call **1-800-337-4770**.

**Behavioral Health Resource** – When dealing with behavioral health issues like depression, anxiety, substance abuse or eating disorders, extra support can make a big difference. Our caring professionals will work with you to arrange counseling and support services that meet your individual and family needs. Just call **1-866-785-2789**.

**ConditionCare** – Get support from a dedicated nurse team to manage ongoing conditions like asthma, chronic obstructive pulmonary disorder (COPD), diabetes, heart disease or heart failure. Work with dietitians, health educators and pharmacists who can help you learn about your condition and manage your health.

**Future Moms** – This program can help you take care of yourself and your baby before, during and after pregnancy. You can talk to registered nurses 24/7 about your pregnancy, newborn care and more. Plus, you'll have access to dietitians and social workers, as needed. The program also includes breastfeeding support on LiveHealth Online.

## Want healthy advice?

Follow our **Better Care Blog** for helpful information about health benefits, living healthy and the latest member news.





## Plan extras that support your health

Learn more by registering on the **Sydney** mobile app or at **anthem.com**.

**LiveHealth Online** — At home, at work or on the go, you can have a video visit with a doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7 for advice, treatment and prescriptions if needed.\* The cost is usually \$59 or less, depending on your health plan. Register at **livehealthonline.com**.

\* Online prescribing only when appropriate based on physician judgment. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Summary of Benefits of Coverage  
(SBC's)


Effective January 1-December 31, 2020



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 833-597-2358 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall Calendar Year <a href="#">deductible</a>?</p>	<p>\$500/member or <b>\$1,000</b>/family for In-<a href="#">Network Providers</a>.                      \$500/ member or <b>\$1,000</b>/family for Out-of-<a href="#">Network Providers</a>.</p>	<p>Generally you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. In-<a href="#">Network Preventive care</a> and annual Vision exam for In-<a href="#">Network Providers</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>Yes. <b>\$150</b> individual/<b>\$300</b> family deductible for Brand, Non Preferred Brand and Specialty prescription medication  <b>\$3,000</b>/ member or <b>\$6,000</b>/family for In-<a href="#">Network Providers</a>. <b>\$4,500</b>/ member or <b>\$9,000</b>/family for Out-of-<a href="#">Network Providers</a>.                      For in-network prescription drugs; <b>\$3,600</b> individual/<b>\$7,200</b> family.</p>	<p>Yes. You do have to meet <a href="#">deductibles</a> for Brand, Non Preferred Brand and Specialty prescription medications.</p>
<p>What is the <a href="#">Medical out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>Cost share of routine vision care, <a href="#">Premiums</a>, <a href="#">Balanced-Billed</a> charges, and Health Care this <a href="#">plan</a> doesn't cover.</p>	<p>The Medical <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. Doesn't include outpatient prescription drug cost shares.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Yes, KeyCare. See <a href="http://www.anthem.com">www.anthem.com</a> or call 833-597-</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes, KeyCare. See <a href="http://www.anthem.com">www.anthem.com</a> or call 833-597-</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance</a></p>

Important Questions	Answers	Why This Matters:
	2358 for a list of <a href="#">Network Providers</a> .	Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, deductible & coinsurance do not apply to copay services.

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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$40 copay/visit	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening</a> /immunization	No cost share	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 PCP/\$40 specialist copay/visit OR 20% Coinsurance in a facility setting	30% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Preauthorization required
If you need drugs to treat your illness or condition	<a href="#">Generic</a>	<b>Retail:</b> \$10 copay/prescription <b>Mail Order:</b> \$10 copay / prescription	Not covered	Pharmacy member cost shares do not count towards the Medical out-of-pocket maximum.
	<a href="#">Brand</a> Your plan has a deductible of <b>\$150</b> for a single person and <b>\$300</b> for a family. The cost share amounts to the right apply once you meet the deductible.	<b>Retail:</b> 30% coinsurance with a minimum of \$40 (unless cost of drug is < \$40) and a maximum of \$80; <b>Mail Order:</b> 30% coinsurance with a minimum of \$80 (unless cost of drug is < \$80) and a maximum of \$160	Not covered	

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)	
	<p><b><u>Non Preferred Brand</u></b> Your plan has a deductible of <b>\$150</b> for a single person and <b>\$300</b> for a family. The cost share amounts to the right apply once you meet the deductible.</p>	<p><b>Retail:</b> 40% coinsurance with a minimum of \$60 (unless cost of drug is &lt; \$60) and a maximum of \$120 <b>Mail Order:</b> 40% coinsurance with a minimum of \$120 (unless cost of drug is &lt; \$120) and a maximum of \$240</p>	Not covered	
	<p><b><u>Specialty (30 day supply only)</u></b> Your plan has a deductible of <b>\$150</b> for a single person and <b>\$300</b> for a family. The copayment amounts to the right apply once you meet the deductible.</p>	<p><b>MedImpact Direct Specialty:</b> 50% to \$200 per script maximum</p>	Not covered	
	<p><b><u>Preventive Rx</u></b> – Medications on MedImpact Preventive Rx Drug List</p>	No cost	No cost	Limited to drugs on MedImpact's standard preventive drug list.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<b><u>Emergency room care</u></b>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	<b><u>Emergency medical transportation</u></b>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	<b><u>Urgent care</u></b>	\$20 PCP / \$40 Spec. copay/visit	30% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Precertification required.
	Physician/surgeon fee	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or	Outpatient services	Office Visit \$20 copay/visit Other Outpatient No cost share	Office Visit 30% <a href="#">coinsurance</a> Outpatient 30% <a href="#">coinsurance</a>	-----none-----
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Precertification required.

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)	
substance abuse needs	Office visits	\$20 PCP/\$40 specialist copay/pregnancy	30% <a href="#">coinsurance</a>	One-time copay for initial visit to confirm pregnancy and all pre- and postnatal office visits (excluding inpatient stays & diagnostic testing).
	Childbirth/delivery professional services (OB Dr.)	See above	30% <a href="#">coinsurance</a>	
If you are pregnant	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	90 visits/per calendar year.
	<a href="#">Home health care</a>	No cost share	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Rehabilitation services</a>	Physical & Occupational Therapy: \$30 copay/visit Speech Therapy: \$20 PCP/\$40 specialist copay/visit	30% <a href="#">coinsurance</a>	There is a 30-visit limit for physical and occupational therapy, combined. 30-visit limit for speech therapy. Early Intervention Services Pre-determination of eligibility required.
		Physical & Occupational Therapy: \$30 copay/visit Speech Therapy: \$20 PCP/\$40 specialist copay/visit	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 day per stay limit; pre-authorization required.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Hospice service</a>	No cost share	30% <a href="#">coinsurance</a>	-----none-----



Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	\$15 copay/ visit	One routine exam per calendar year. -----none----- -----none-----
	Children's glasses	Not covered	
	Children's dental check-up	Not covered	

**Excluded Services & Other Covered Services:**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)	
Acupuncture Cosmetic surgery Dental care	Hearing aids Infertility treatment Long term care  Routine foot care other than for Diabetes

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. Adult Routine Eye Exams Autism Spectrum Disorder	Coverage provided outside the United States. See <a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a>  Private-duty nursing 16 hours/member/benefit period  Morbid Obesity Services

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 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: Anthem [Grievance](#) and [Appeals](#) P.O. Box 27401, Atlanta, Richmond, VA 23279.

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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](#) \$500
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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** \$12,840

In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$2,444*
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,000*</b>

\*Peg met **\$3,000 OOP maximum**

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

- The [plan's](#) overall [deductible](#) \$500
- [Primary Care copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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** \$7,460

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$160
<a href="#">Coinsurance</a>	\$1,360
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,020</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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** \$2,010

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$150
<a href="#">Coinsurance</a>	\$272
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$922</b>

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



## Language Access Services:

معلومات و کمک را بدون هیچ هزینه ای به زبان مادرتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 833-597-2358 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 833-597-2358.

**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 833-597-2358.

**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 833-597-2358.

**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. 833-597-2358.

**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 833-597-2358.

**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 833-597-2358 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntauv 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 833-597-2358.

**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 833-597-2358.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulog ken impormasyon babaaen ti lenguaheh nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti 833-597-2358.

**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 833-597-2358.

## Language Access Services:

**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 833-597-2358

**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、833-597-2358 にお電話ください。

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសាសំអ្នកដោយឥតគិតថ្លៃ។ ដើម្បីស្វែងយល់កិច្ចការអ្នកបកប្រែ សូមហៅ 833-597-2358 ។

**Kirundi (Kirundi):** Ugize ikibazo icyo arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 833-597-2358.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 833-597-2358 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໃຊ້ບໍລິການກັບວ່າມແປພາສາ, ໃຫ້ໃບທາ 833-597-2358.

**Navajo (Diné):** Dii naaltsoos bika'igii lahgo bina'idilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjī bee nit hodoonih t'áadoo bááh ílínígóó. Ata' halne'igii' la' bich'i' hadeesdzih nínizingo kojī' hodiilnih 833-597-2358.

**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 833-597-2358

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 833-597-2358 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwwer 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 833-597-2358.

## 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 833-597-2358.

**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 833-597-2358.

**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 ਦੁਆਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 833-597-2358 ਤੇ ਕਾਲ ਕਰੋ।

**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 833-597-2358.

**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. 833-597-2358.

**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 totogi. Ina ia talanoa i se tagata faaliliu, vili 833-597-2358.

**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 833-597-2358.

**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 833-597-2358.

**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 833-597-2358.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 833-597-2358 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: 833-597-2358.

## Language Access Services:

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لیے، 833-597-2358 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 833-597-2358.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהרין פרייז. צו רעדן צו אן איבערזעצער, רופט 833-597-2358.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkòsílẹ̀ yì, o ní ètọ́ láti gba iranwọ̀ àti iwífún ní èdè rẹ̀ lófẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe 833-597-2358.

## It's important we treat you fairly

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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 with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.





The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 833-597-2358 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall Calendar Year <a href="#">deductible</a>?</p>	<p>\$3,000 / member or \$6,000 / family for In-<a href="#">Network Providers</a> and Out-of-<a href="#">Network Providers</a> <a href="#">combined</a>.</p>	<p>Generally you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. In-<a href="#">Network Preventive care</a> and annual Vision exam for In-<a href="#">Network Providers</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the Medical and Prescription <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>\$3,000 / member or \$6,000 / family for In-<a href="#">Network Providers</a>. \$6,000 / member or \$12,000 / family for Out-of-<a href="#">Network Providers</a>.</p>	<p>The Medical and Prescription <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p>What is not included in the <a href="#">out-of-pocket limit</a>?</p>	<p>Cost share of routine vision care, <a href="#">Premiums</a>, <a href="#">Balanced-Billed</a> charges, and Health Care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p>Will you pay less if you use a <a href="#">network provider</a>?</p>	<p>Yes, KeyCare. See <a href="http://www.anthem.com">www.anthem.com</a> or call 833-597-2358 for a list of <a href="#">Network Providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met.

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 <a href="#">provider's office</a> or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/ screening/immunization</a>	No cost share	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Preauthorization required
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://mp.medim pact.com/VPCBC">https://mp.medim pact.com/VPCBC</a>	<a href="#">Generic</a> (\$3,000 individual/ \$6,000 family overall deductible_applies)	0% <a href="#">coinsurance</a>	Not covered	<b>Coinurance applies AFTER the deductible.</b> Pharmacy member cost shares count towards the Medical out-of-pocket maximum.
	<a href="#">Brand</a> (\$3,000 individual/ \$6,000 family overall deductible applies)	0% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Non Preferred Brand</a> (\$3,000 individual/ \$6,000 family overall deductible applies)	0% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Specialty (30 day supply only)</a> (\$3,000 individual/ \$6,000 family overall deductible applies)	<b>MedImpact Direct Specialty:</b> 0% <a href="#">coinsurance</a>	Not covered	

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 have outpatient surgery	<b>Preventive Rx</b> – Medications on MedImpact Preventive Rx Drug List	Not subject to the deductible/No cost	Not subject to the deductible/No cost*	Limited to drugs on MedImpact's standard preventive drug list.
	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-certification required.
	Physician/surgeon fee	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Outpatient services	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse needs	Inpatient services	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Pre-certification required.
	Office visits	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery professional services (OB Dr.)	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	90 visit maximum/per calendar year.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	There is a 30-visit limit for physical and occupational therapy, combined. 30-visit limit for speech therapy. Early Intervention Services Pre-determination of eligibility required.
If you need help recovering or have other special health needs	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 day per stay limit; pre-authorization required.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Hospice service</a>	0% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----

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)	
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	\$15 copay/ visit	\$30 allowance/visit	One routine exam per calendar year.
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----none-----

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)	
Acupuncture Cosmetic surgery Dental care	Hearing aids Infertility treatment Long term care
	Routine foot care other than for Diabetes Morbid Obesity Services

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
Chiropractic care 30 visits/benefit period. Adult Routine Eye Exams Autism Spectrum Disorder	Coverage provided outside the United States. See <a href="http://www.bcbs.com/bluecardworldwide">www.bcbs.com/bluecardworldwide</a>  Private-duty nursing 16 hours/member/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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 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: Anthem **Grievance** and **Appeals** P.O. Box 27401, Atlanta, Richmond, VA 23279.

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

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

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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](#) **\$3,000**
- [Specialist coinsurance](#) **0%**
- Hospital (facility) [coinsurance](#) **0%**
- Other [coinsurance](#) **0%**

This **EXAMPLE** event includes services like:

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

**Total Example Cost** **\$12,840**

In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,000*</b>

*Met \$3,000 OOP maximum\**

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- [Primary Care coinsurance](#) **0%**
- Hospital (facility) [coinsurance](#) **0%**
- Other [coinsurance](#) **0%**

This **EXAMPLE** event includes services like:

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

**Total Example Cost** **\$7,460**

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,000*</b>

*Met \$3,000 OOP maximum\**

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- [Specialist coinsurance](#) **0%**
- Hospital (facility) [coinsurance](#) **0%**
- Other [coinsurance](#) **0%**

This **EXAMPLE** event includes services like:

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

**Total Example Cost** **\$2,010**

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,010
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,010</b>

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



## Language Access Services:

فارسى (فارسي) : در صورتی که مؤالی 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 833-597-2358 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 833-597-2358.

**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 833-597-2358.

**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 833-597-2358.

**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. 833-597-2358.

**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 833-597-2358.

**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 833-597-2358 ।

**Hmong (White Hmong) :** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv 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 833-597-2358.

**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 833-597-2358.

**Ilokano (Ilokano) :** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulog ken impormasyon babaaen ti lenguaheh nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti 833-597-2358.

**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 833-597-2358.



## Language Access Services:

**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 833-597-2358

**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、833-597-2358 にお電話ください。

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសាសំអ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីស្វែងរកជាមួយអ្នកបកប្រែ សូមហៅ 833-597-2358 ។

**Kirundi (Kirundi):** Ugize ikibazo icyo arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 833-597-2358.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 833-597-2358 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໃຊ້ບໍລິການກັບວ່າມແປພາສາ, ໃຫ້ໃບທາ 833-597-2358.

**Navajo (Diné):** Dii naaltsoos bika'igií lahgo bina'idilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjī bee nit hodoonih t'áadoo bááh ílínigóó. Ata' halne'igií la' bich'i' hadeesdzih nínizingo kojī' hodiilnih 833-597-2358.

**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 833-597-2358

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 833-597-2358 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwwer 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 833-597-2358.

## 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 833-597-2358.

**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 833-597-2358.

**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, 833-597-2358 ਤੇ ਕਾਲ ਕਰੋ।

**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 833-597-2358.

**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. 833-597-2358.

**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 totogi. Ina ia talanoa i se tagata faaliliu, vili 833-597-2358.

**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 833-597-2358.

**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 833-597-2358.

**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 833-597-2358.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร 833-597-2358 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: 833-597-2358.

## Language Access Services:

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لیے، پر کال کریں۔ 833-597-2358

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 833-597-2358.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט 833-597-2358.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkòsílẹ̀ yì, o ní ètọ́ láti gba iranwọ̀ àti iwífún ní èdè rẹ̀ ló fẹ́. Bá wa ògbùfọ̀ kan sọ rẹ, pe 833-597-2358.

## 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 with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Anthem Medical  
Summary of Benefits

Effective January 1-December 31, 2020

## PPO Plan 4

January 1, 2020 – December 31, 2020

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at [www.anthem.com](http://www.anthem.com). Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

### DEDUCTIBLE DOES NOT APPLY FOR SERVICES WHERE THERE IS A FLAT COPAY

In-Network Services (Not subject to calendar year deductible)	You Pay
<b>Preventive Care Services</b>	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.	<b>No charge*</b>
* During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	
<b>Doctor Visits</b>	
<ul style="list-style-type: none"> <li>○ office visits</li> <li>○ urgent care visits</li> <li>○ home visits</li> <li>○ pre- and postnatal office visits</li> <li>○ spinal manipulations and other manual medical intervention visits (30 visit limit per CY)</li> <li>○ in-office surgery</li> </ul>	<b>\$20</b> for each visit to a family or general practitioner, internist or pediatrician  <b>\$40</b> for each visit to a specialist
<ul style="list-style-type: none"> <li>○ speech therapy visits in an office setting (30 visit limit per CY)</li> <li>○ diagnostic lab and x-ray services performed in a physician's office</li> <li>○ early intervention</li> <li>○ allergy testing</li> </ul>	
<ul style="list-style-type: none"> <li>○ online visits (<a href="https://livehealthonline.com">https://livehealthonline.com</a>) (does not include livehealthonline mental health/substance abuse therapist visits)</li> </ul>	<b>\$10</b> for each visit
<ul style="list-style-type: none"> <li>○ physical and occupational therapy in an office setting (combined 30 visit limit per CY)</li> </ul>	<b>\$30</b> for each visit to a specialist
<ul style="list-style-type: none"> <li>○ mental health conditions and substance use disorder visits (including LHO therapist visits)</li> </ul>	<b>\$20</b> for each visit
<ul style="list-style-type: none"> <li>○ allergy shots/serum</li> </ul> <p><b>*If services are billed with an office visit charge, the office visit copay will apply</b></p>	<b>No Charge*</b>
<b>Routine Vision</b>	
<ul style="list-style-type: none"> <li>○ annual routine eye exam</li> </ul> <p><b>Plus – valuable discounts on eyewear</b></p>	<b>\$15</b> for each visit

All Other In-Network Services	You Pay
<p>You will pay all the costs associated with your care until you have paid \$500 in one calendar year. This is known as your deductible.</p>	
<ul style="list-style-type: none"> <li>○ If two people are covered under your plan, each of you will pay the first \$500 of the cost of your care (\$1,000 total).</li> <li>○ If three or more people are covered under your plan, together you will pay the first \$1,000 of the cost of your care. However, the most one family member will pay is \$500.</li> <li>○ The deductible is included in the out-of-pocket maximum.</li> </ul>	
<p><b>Once you reach your deductible you pay: (DEDUCTIBLE DOES NOT APPLY TO FLAT COPAY SERVICES)</b></p>	
<p><b>Maternity Services</b></p>	
<ul style="list-style-type: none"> <li>○ initial visit to confirm pregnancy and all routine pre- and postnatal office visits (excluding inpatient stays)</li> </ul>	<p>One time copay of <b>\$20</b> to PCP or <b>\$40</b> to a specialist (deductible does not apply)</p>
<ul style="list-style-type: none"> <li>○ diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures)</li> </ul>	<p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>
<p><b>Autism Spectrum Disorder (ASD)</b></p>	
<ul style="list-style-type: none"> <li>○ Behavioral Health Treatment: mental health services</li> </ul>	<p><b>Office Visit: \$20</b> for each visit (deductible does not apply)  <b>Outpatient Facility: 0%</b> (after meeting deductible)  <b>Inpatient Facility: 20%</b> (after meeting deductible)</p>
<ul style="list-style-type: none"> <li>○ Pharmacy Care</li> </ul>	<p><b>Office Visit: \$20</b> for each visit (deductible does not apply)</p>
<ul style="list-style-type: none"> <li>○ Psychiatric Care</li> </ul>	<p><b>Office Visit: \$20</b> for each visit (deductible does not apply)  <b>Outpatient Facility: 0%</b> (after meeting deductible)  <b>Inpatient Facility: 20%</b> (after meeting deductible)</p>
<ul style="list-style-type: none"> <li>○ Psychological Care</li> </ul>	<p><b>Office Visit: \$20</b> for each visit (deductible does not apply)  <b>Outpatient Facility: 0%</b> (after meeting deductible)  <b>Inpatient Facility: 20%</b> (after meeting deductible)</p>
<ul style="list-style-type: none"> <li>○ Therapeutic Care: unlimited physical, occupational and speech therapy</li> </ul>	<p><b>Office Visit: \$20</b> for each visit to a family or general practitioner, internist or pediatrician; <b>\$40</b> for each visit to a specialist (deductible does not apply)  <b>Outpatient Facility: \$40</b> for each visit to a specialist (deductible does not apply)</p>
<ul style="list-style-type: none"> <li>○ Applied Behavioral Analysis</li> </ul>	<p><b>No charge</b> (deductible does not apply)</p>
<p><b>Labs, X-rays and Other Outpatient Services</b></p>	
<ul style="list-style-type: none"> <li>○ respiratory therapy</li> <li>○ shots and therapeutic injections (other than allergy shots)</li> <li>○ dialysis</li> <li>○ chemotherapy (not given orally)</li> <li>○ diagnostic lab and x-ray services performed outside a physician's office</li> <li>○ medical appliances, supplies and medications, including infusion medications</li> <li>○ complex diagnostic imaging (requires pre-authorization)</li> <li>○ professional ground ambulance services</li> <li>○ durable medical equipment</li> <li>○ radiation therapy</li> </ul>	<p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>

In-Network Services	You Pay
<b>Outpatient Visits in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ emergency room</li> <li>○ surgery</li> <li>○ physician services</li> </ul>	20% of the amount the health care professionals in our network have agreed to accept for their services
○ physical therapy and occupational therapy (combined 30 visit limit per CY)	\$30 per visit to a specialist (deductible does not apply)
○ speech therapy (30 visit limit per CY)	\$20 per visit to your PCP \$40 per visit to a specialist (deductible does not apply)
○ mental health conditions and substance use disorder	0% of the amount the health care professionals in our network have agreed to accept for their services
<b>Care at Home</b>	
<ul style="list-style-type: none"> <li>○ home health care visits by a nurse or aide (90 visits)</li> <li>○ hospice care</li> <li>○ private duty nursing (16 hours per member per year)</li> </ul>	<b>No charge</b> (deductible does not apply)
<b>Inpatient Stays in a Network Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ semi-private room, intensive care or similar unit (includes inpatient mental health/substance abuse admission and maternity admissions; requires pre-authorization)</li> <li>○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services</li> <li>○ skilled nursing facility care (100 days for each admission and requires pre-authorization)</li> <li>○ mental health conditions and substance use disorders partial-day treatment programs</li> </ul>	20% of the amount the health care professionals in our network have agreed to accept for their services

**For benefits listed with specific limits all services received during the calendar year from January 1 and December 31 for that benefit are applied to that limit (whether received in or out-of-network). Your deductible amount begins anew on January 1 each year. Any amount you pay toward your deductible during the 4th quarter of each calendar year—October, November, December—will apply not only to your deductible for that year but will also apply to your deductible for the following year.**

**The outpatient pharmacy benefit is administered separately by MedImpact. See separate MedImpact materials for more information. Out of Pocket Outpatient prescription drug cost shares do not count towards the Medical Out-of-pocket maximum listed on the next page.**

Out-of-Network Services
<b>Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits</b>
<p>It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$500 in one calendar year. This is called your out-of-network deductible.</p> <ul style="list-style-type: none"> <li>○ If two people are covered under your plan, each of you will pay the first \$500 of the cost of your care (\$1,000 total).</li> <li>○ If three or more people are covered under your plan, together you will pay the first \$1,000 of the cost of your care. However, the most one family member will pay is \$500.</li> <li>○ The out-of-network deductible is not combined with the in-network deductible.</li> </ul> <p>Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$500 out-of-network deductible) and you will pay the rest of what the professional charges.</p>

## Out-of-Pocket Maximums

### What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

#### When using network professionals

If you are the only one covered by your plan, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.\*

- If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).
- If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.

#### When not using network professionals

If you are the only one covered by your plan, you will pay \$4,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.\*

- If two people are covered under your plan, each of you will pay \$4,500 (\$9,000 total).
- If three or more people are covered under your plan, together you will pay \$9,000. However, no family member will pay more than \$4,500 toward the limit.
- The out-of-network out-of-pocket maximum is not combined with the in-network out-of-pocket maximum.

#### \*The following do not count toward the calendar year out-of-pocket maximum:

- your share of the cost of prescription drugs and routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your PPO plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

*This benefits overview insert is only one piece of your entire enrollment package.  
See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*



## PPO Plan 7

January 1, 2020 – December 31, 2020

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at [www.anthem.com](http://www.anthem.com). Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

In-Network Services	You Pay	
<b>Preventive Care Services</b>		
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.  * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	<b>No charge*</b>	
<b>Routine Vision</b>		
<ul style="list-style-type: none"> <li>○ annual routine eye exam</li> <li style="padding-left: 20px;"><i>Plus – valuable discounts on eyewear</i></li> </ul> <p>If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached your deductible) and you will pay the rest of what the provider charges.</p>	<b>\$15 for each visit</b>	
<b>Annual Deductible</b>		
<p>Your deductible is combined for In-network and Out-of-Network services.</p> <ul style="list-style-type: none"> <li>○ For single coverage, you will pay all the costs associated with your care until you have paid \$3,000 in one calendar or plan year.</li> <li>○ If two people are covered under your plan, each of you will pay the first \$3,000 of the cost of your care (\$6,000 total).</li> <li>○ If three or more people are covered under your plan, together you will pay the first \$6,000 of the cost of your care. However, the most one family member will pay is \$3,000.</li> </ul> <p><b>In-Network Services</b> Once you and your covered family members have reached your deductible, you will pay the amounts designed below in the “you pay” column.</p> <p><b>Out-of-Network Services</b> For covered services to out-of-network providers, you will pay 40%. However, it's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts.</p>		
<b>Once you reach your deductible, you will pay the following for covered in-network services</b>		
<b>All Other In-Network Services</b>		
<b>Doctor Visits</b>		
<ul style="list-style-type: none"> <li>○ office visits</li> <li>○ urgent care visits</li> <li>○ home visits</li> <li>○ pre- and postnatal office visits</li> <li>○ mental health and substance use disorder visits</li> <li>○ in-office surgery</li> <li>○ online sick visits (<a href="https://livehealthonline.com">https://livehealthonline.com</a>) You won't pay more than the \$59 LHO allowable charge/visit.</li> <li>○ online MHSA visits (<a href="https://livehealthonline.com">https://livehealthonline.com</a>)</li> </ul> <p>* <i>Limit does not apply to Autism Spectrum Disorder.</i></p>	<ul style="list-style-type: none"> <li>○ physical and occupational therapy in an office setting (30 combined visits)*</li> <li>○ speech therapy visits in an office setting (30 visit limit)*</li> <li>○ spinal manipulations and other manual medical intervention visits (30 visit limit)</li> </ul>	<b>0% of the amount the health care professionals in our network have agreed to accept for their services</b>
<b>Labs, Diagnostic X-rays and Other Outpatient Services</b>		
<ul style="list-style-type: none"> <li>○ diagnostic lab services</li> <li>○ shots and therapeutic injections</li> <li>○ medical appliances, supplies and medications, including infusion medications</li> <li>○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy</li> </ul>	<ul style="list-style-type: none"> <li>○ diagnostic x-rays</li> <li>○ dialysis</li> <li>○ ambulance travel</li> <li>○ durable medical equipment</li> </ul>	<b>0% of the amount the health care professionals in our network have agreed to accept for their services</b>
<ul style="list-style-type: none"> <li>○ diabetic supplies, equipment and education</li> </ul>		<b>0% of the amount the health care professionals in our network have agreed to accept for their services</b>

<b>Autism Spectrum Disorder (ASD)</b>	
<ul style="list-style-type: none"> <li>○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> <li>○ behavioral health treatment*</li> <li>○ psychiatric care</li> <li>○ therapeutic care**</li> <li>○ pharmacy care (office or facility setting)</li> <li>○ psychological care</li> </ul> </li> </ul> <p><b>* Mental Health Services</b>  <b>**Unlimited physical, occupational and speech therapy.</b></p>	0% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> <li>○ applied behavioral analysis</li> </ul>	0% of the amount the health care professionals in our network have agreed to accept for their services
<b>Early Intervention – For children from birth up to age 3</b>	
<ul style="list-style-type: none"> <li>○ unlimited per member per calendar year up to age 3</li> </ul>	0% of the amount the health care professionals in our network have agreed to accept for their services
<b>Outpatient Visits in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ physical therapy and occupational therapy (30 combined visits)*</li> <li>○ speech therapy (30 visit limit)*</li> <li>○ surgery</li> <li>○ emergency room</li> <li>○ physician services</li> <li>○ mental health and substance use partial-day treatment programs</li> </ul> <p><b>* Limit does not apply to Autism Spectrum Disorder.</b></p>	0% of the amount the health care professionals in our network have agreed to accept for their services
<b>Care at Home</b>	
<ul style="list-style-type: none"> <li>○ home health care (100 visits)</li> <li>○ private duty nursing is limited to 16 hours per member per calendar year*</li> </ul> <p><b>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.</b></p>	0% of the amount the health care professionals in our network have agreed to accept for their services
<b>Inpatient Stays in a Network Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ semi-private room, intensive care or similar unit</li> <li>○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services</li> <li>○ skilled nursing facility care (100 days for each admission)</li> </ul>	0% of the amount the health care professionals in our network have agreed to accept for their services

**The outpatient pharmacy benefit is administered separately by MedImpact. See separate MedImpact materials for more information. Out of Pocket Outpatient prescription drug cost shares count towards the Medical Out-of-pocket maximum listed on the next page.**

Your benefit period is a calendar year. A calendar year means your benefit period runs from January through December.

*For benefits listed with specific limits all services received in the calendar year or plan year for that benefit are applied to that limit (whether received in or out of network).*

## Out-of-Pocket Maximums

### What You Will Pay for Covered Services in One Calendar Year

#### When using network professionals

For single coverage, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan; together you will pay \$6,000. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

#### When not using network professionals

For single coverage, you will pay \$6,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan; together you will pay \$12,000. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

The following do not count toward the calendar year out-of-pocket maximum:

- your share of the cost of adult routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

*This benefits overview insert is only one piece of your entire enrollment package.*

*See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

09.25.2016bcr

Exam Only A15 Plan

**Welcome to your Blue View Vision plan!**

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice eye care doctors. Our network also has many convenient optical stores, including popular national retail stores LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. When you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. To locate a participating network eye care doctor or location, log in at [anthem.com](http://anthem.com), or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at the number on the back of your ID card.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
<b>Routine Eye Exam</b>			
A comprehensive eye examination	\$15 copay	Up to \$30 allowance	Once every calendar year

**USING YOUR BLUE VIEW VISION PLAN**

When you are ready to schedule your eye exam, just make an appointment with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.

**ADDITIONAL SAVINGS ON EYEWEAR AND MORE**

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

**OUT-OF-NETWORK**

If you choose to, you may receive covered services outside of the Blue View Vision network. If you choose an out-of-network doctor, you must pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. To download a claim form, log in at [anthem.com](http://anthem.com), or from the home page menu locate Support and select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form. To request reimbursement for out-of-network services, complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below.

**To Fax:** 866-293-7373  
**To Email:** [oonclaims@eyewearspecialoffers.com](mailto:oonclaims@eyewearspecialoffers.com)  
**To Mail:** Blue View Vision  
Attn: OON Claims  
P.O. Box 8504  
Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit [anthem.com](http://anthem.com) or call us at the number on the back of your ID card.

This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		Member Pays
<b>Retinal Imaging</b>	<ul style="list-style-type: none"> <li>At member's option can be performed at time of eye exam</li> </ul>	Not more than \$39
<b>Eyeglass Frame</b>	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*</li> </ul>	35% off retail price
<b>Eyeglass Lenses</b> Standard plastic material	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*:               <ul style="list-style-type: none"> <li>Single Vision \$50</li> <li>Bifocal \$70</li> <li>Trifocal \$105</li> </ul> </li> </ul>	
<b>Eyeglass Lens Options and Upgrades</b> When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*:               <ul style="list-style-type: none"> <li>UV Coating \$15</li> <li>Tint (Solid and Gradient) \$15</li> <li>Standard Scratch-Resistant Coating \$15</li> <li>Standard Polycarbonate \$40</li> <li>Standard Anti-Reflective Coating \$45</li> <li>Standard Progressive Lenses (add-on to Bifocal) \$65</li> <li>Other Add-Ons 20% off retail price</li> </ul> </li> </ul>	
<b>Conventional Contact Lenses</b> (non-disposable type)	<ul style="list-style-type: none"> <li>Discount applies to materials only</li> </ul>	15% off retail price

\* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not 'covered benefits' under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where state law prevents discounting of products and services that are not covered benefits under the plan. Discounts on frames will not apply if the manufacturer has imposed a no discount policy on sales at retail and independent provider locations.

Some of the Blue View Vision participating in-network providers include:



**ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM**

Other savings offers are available on eyewear, hearing aids and even LASIK laser vision correction surgery through a variety of vendors. Just **log in at [anthem.com](http://anthem.com)**, select discounts, then Vision, Hearing & Dental.

# Take care of yourself

## Use your preventive care benefits



And Its Affiliate HealthKeepers, Inc.

Getting regular checkups and exams can help you stay healthy and catch problems early — when they're easier to treat.

That's why our health plans offer all the preventive care services and immunizations below — at no cost to you.<sup>1</sup> As long as you see a doctor in the plan, you won't have to pay anything for these services and immunizations. If you want to visit a doctor outside the plan, you may have to pay out of pocket.

Not sure which services make sense for you? Talk to your doctor. He or she can help you figure out what you need.

### Preventive vs. diagnostic care

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

#### Preventive physical exams

##### Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening\*
- Eye chart test for vision<sup>2</sup>
- Hearing screening
- Height, weight and body mass index (BMI)
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years<sup>3</sup>
- Obesity: related screening and counseling
- Prostate cancer, 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
- Violence, interpersonal and domestic: related screening and counseling

##### 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)

##### Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met<sup>4</sup>
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling<sup>5,6,7</sup>
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening<sup>6</sup>
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression<sup>6</sup>
- Pelvic exam and Pap test, including screening for cervical cancer

These preventive care services are recommendations of the Affordable Care Act (ACA or health care reform law). They may not be right for every person, so 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 provisions of the group policy will rule. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for exclusions and limitations.*

\* CDC-recognized Diabetes Prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

## Child preventive care

### Preventive physical exams

#### Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and BMI
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24 with fair skin about lowering their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening when done as part of a preventive care visit<sup>2</sup>

#### Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type b (Hib)
- Hepatitis A and hepatitis B
- HPV
- Meningitis
- MMR
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

<sup>1</sup> 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.

<sup>2</sup> Some plans cover additional vision services. Please see your contract or *Certificate of Coverage* for details.

<sup>3</sup> You may be required to get preapproval for these services.

<sup>4</sup> Check your medical policy for details.

<sup>5</sup> Breast pumps and supplies must be purchased from plan providers for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

<sup>6</sup> This benefit also applies to those younger than age 19.

<sup>7</sup> Counseling services for breastfeeding (lactation) can be provided or supported by a plan doctor or hospital provider, such as a pediatrician, obstetrician/gynecologist or family medicine doctor, and hospitals with no member cost share (deductible, copay, coinsurance). Contact the provider to see if such services are available.

# LiveHealth Online

Sign up today — so you're ready for a video visit when you need it



Using LiveHealth Online, you can have a private and secure video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer with a webcam. It's an easy way to get the care you need at home or on the go.

When your own doctor isn't available, use LiveHealth Online 24/7 if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or other common health condition. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if it's needed.<sup>1</sup>

## How to get started

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

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

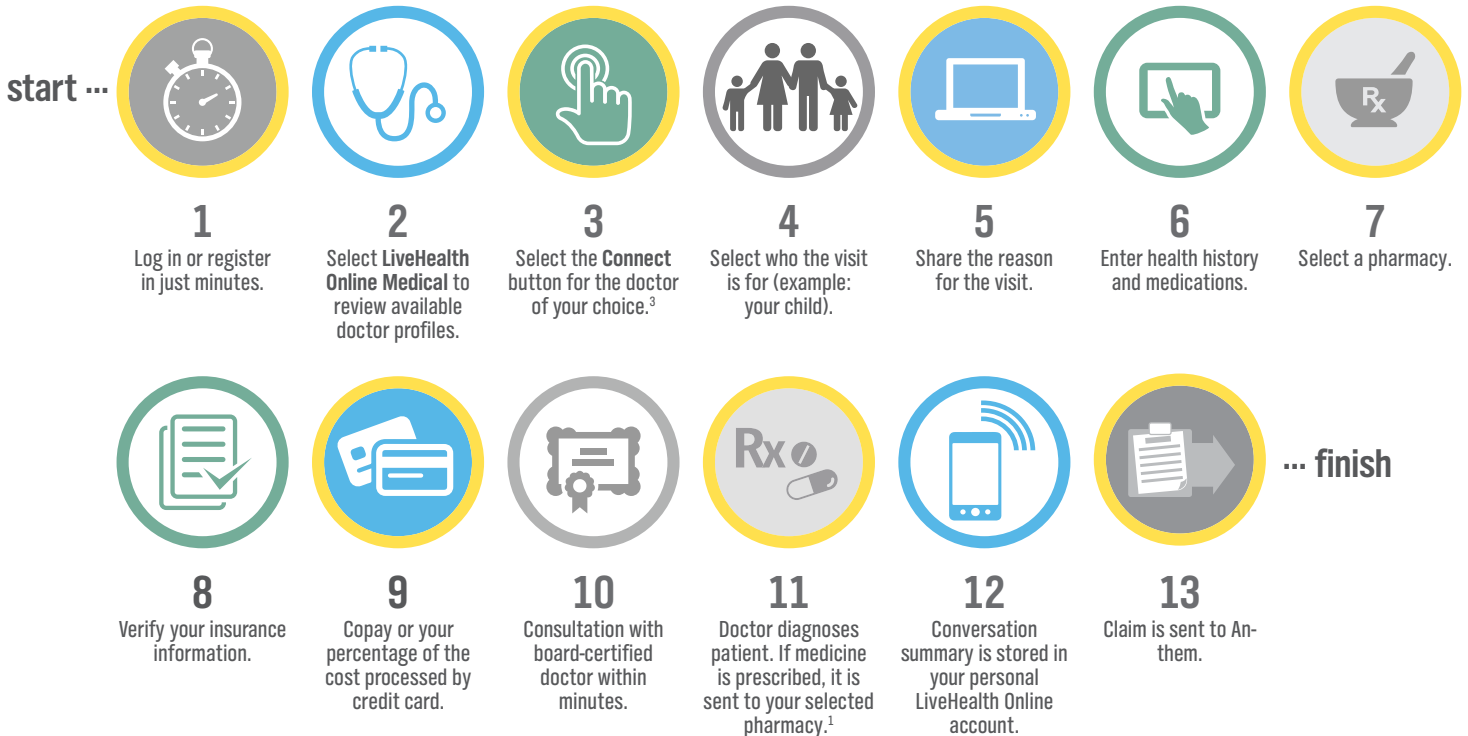




## Your account securely stores your personal and health information

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

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



The steps to set up an appointment with a therapist using **LiveHealth Online Psychology** are very similar to seeing a doctor. You need to select **LiveHealth Online Psychology** to see available therapists and schedule an appointment.

### Questions about how to use LiveHealth Online?

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

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

<sup>2</sup> Appointments subject to availability of a therapist.

<sup>3</sup> Select a doctor licensed to practice in the state where you're physically located. If that doctor is seeing another patient, you can choose to go to an online waiting room or you can select another doctor who is available at that moment.

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

Psychologists or therapists using LiveHealth Online cannot prescribe medications.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

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

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

# Visit a psychiatrist right from home

Starting January 1, 2018 you can talk to a psychiatrist online to get help with managing your medications.



Now you can visit with a board-certified psychiatrist face-to-face through private and secure video from the comfort of home using LiveHealth Online Psychiatry. Unlike therapists, who offer counseling support, psychiatrists are available to provide an evaluation and medication management to help if you are coping with a common behavioral health condition.

## Easy and convenient

Most people wait an average of 42 days for an in-person psychiatry visit. But by using LiveHealth Online Psychiatry, you can visit a psychiatrist in 14 days or less<sup>1</sup> whether you're at home, work or on the go. All you have to do is sign up at [livehealthonline.com](http://livehealthonline.com) or download the free mobile app to get started.

## Visits are private and secure

During your first 45-minute evaluation, the psychiatrist will assess your condition, discuss past treatment options and make any updates to your medication. The psychiatrist can provide ongoing medication management support through 15-minute follow-up visits.<sup>2</sup>

Scheduling an appointment is easy. Just visit [livehealthonline.com](http://livehealthonline.com) or call **1-888-548-3432**. With your Anthem health plan the cost of an online psychiatry visit is the same as the cost for an in-person visit. As with any online visit, you'll see the total cost before your session begins.

## Commonly treated conditions:

- Anxiety
- Stress
- Depression
- Bipolar disorder
- Obsessive compulsive disorder
- Post-traumatic stress disorder

## Sign up today

At [livehealthonline.com](http://livehealthonline.com) or using the free mobile app.



And Its Affiliate HealthKeepers, Inc.



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

<sup>2</sup> Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy.

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

HealthKeepers, Inc., and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123; is an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

# You're on the go — and so are we

With the Anthem Anywhere app, you can manage your benefits anytime and anywhere you go. Just search for Anthem Anywhere and download the app.



#### Find a doctor

Search for a doctor, specialist, urgent care or hospital close by.



#### Get your ID card

Share, fax, or email your ID card right from your smartphone.



#### Check your claims

Find out what your doctor billed, how much was paid and if you owe anything.



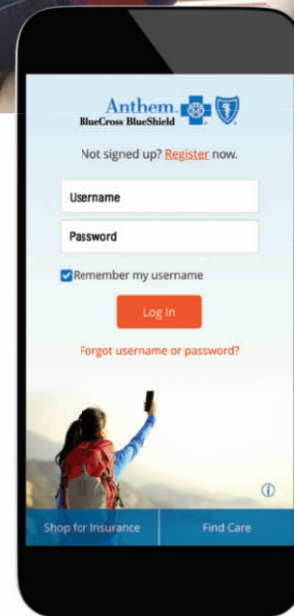
#### Estimate your costs

See what nearby doctors and facilities charge for a procedure. You can compare providers on cost and quality.



#### View your medical benefits

See your copays, deductibles, your percentage of the costs, and other important plan benefit information.



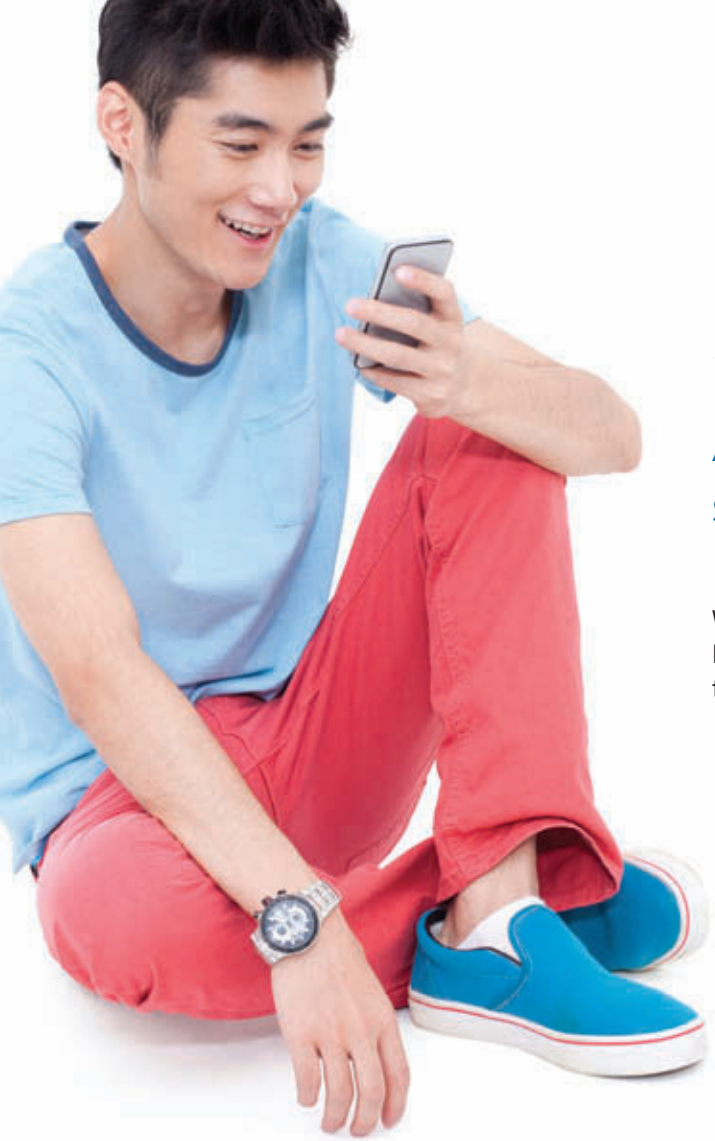
Download the Anthem Anywhere app today.  
Together we can make healthy happen.



Only available on Apple and Android devices

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

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# Say hi to Sydney

Anthem's new app is simple, smart — and all about you

With Sydney, you can find everything you need to know about your Anthem benefits – personalized and all in one place. Sydney makes it easier to get things done, so you can spend more time focused on your health.

**Get started with Sydney**  
Download the app today!



## Simple

Ready for you to use quickly, easily, seamlessly — with one-click access to benefits info, Member Services, wellness resources and more.

## Smart

Sydney acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly.

## Personal

Get alerts, reminders and tips directly from Sydney. Get doctor suggestions based on your needs. The more you use it, the more Sydney can help you stay healthy and save money.

### With just one click, you can:

- Find care and check costs
- Check all benefits
- See claims
- Get answers even faster with our chatbot
- View and use digital ID cards

### Already using one of our apps?

It's easy to make the switch. Simply download the Sydney app and log in with your Anthem username and password.

# Notice of privacy practices

Important information about  
your rights and our responsibilities

THIS NOTICE DESCRIBES HOW MEDICAL, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE READ CAREFULLY.

Protecting your personal health information is important. Each year, we're required to send you specific information about your rights and some of our duties to help keep your information safe. This notice combines three of these required yearly communications:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

Would you like to go paperless and read this online next time? Go to **anthem.com** and sign up to get these notices by email.

## State notice of privacy practices

When it comes to handling your health information, we follow state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.
- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give you additional rights to limit sharing your health information. Please call the Member Services phone number on your ID card for more details.

### Your personal information

▶ Your nonpublic (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may get your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company — without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt out, we'll let you know. We'll also tell you how you can let us know you don't want your PI used or shared for an activity you can opt out of.

## HIPAA notice of privacy practices

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our own rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

### Your protected health information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

**Payment:** We collect, use and share PHI to take care of your account and benefits, or to pay claims for health care you get through your plan.

**Health care operations:** We collect, use and share PHI for your health care operations.

**Treatment activities:** We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may use publicly and/or commercially available data about you so you can get available health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations, visit [anthem.com/privacy](https://www.anthem.com/privacy) for more information.

**Sharing your PHI with you:** We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests.

You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we email you.

**Sharing your PHI with others:** In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

## Your protected health information (continued)

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

### **Other reasons we may use or share your information:**

We are allowed, and in some cases required, to share your information in other ways — usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medicines
  - Reporting suspected abuse neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing workers' compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

**Authorization:** We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

**Genetic information:** We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

**Race, ethnicity and language:** We may receive race, ethnicity and language information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity and language information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.



## Your rights

- ▶ Under federal law, you have the right to:
- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you.
  - Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it.
  - Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
  - Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
  - Send us a written request to ask us for a list of those with whom we've shared your PHI.
  - Ask for a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.
  - Call Member Services at the phone number on your ID card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

## How we protect information

- ▶ We're dedicated to protecting your PHI, and we've set up a number of policies and practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

## Potential impact of other applicable laws

- ▶ HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA.

### Calling or texting you

▶ We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call 1-844-203-3796 to add your phone number to our Do Not Call list. We will then no longer call or text you.

### Complaints

▶ If you think we haven't protected your privacy, you can file a complaint with us at the Member Services phone number on your ID Card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting [hhs.gov/ocr/privacy/hipaa/complaints/](https://www.hhs.gov/ocr/privacy/hipaa/complaints/). We will not take action against you for filing a complaint.

### Contact information

▶ You may call us at the Member Services phone number on your ID card. Our representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

### Copies and changes

▶ You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

### Effective date of this notice

▶ The original effective date of this Notice was April 14, 2003. The most recent revision is noted in the footer at the end of this document.

## Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

You'll pay your usual deductible, copay and/or coinsurance. For details, contact your plan administrator.

For more information about the Women's Health and Cancer Rights Act, go to the United States Department of Labor website at [www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra](https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra).

## It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently based on race, color, national origin, sex, age or disability. If you have disabilities, we offer free aids and services. If your main language isn't English, we offer help for free through interpreters and other written languages. 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 through one of these ways:

- Write to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160 Richmond, VA 23279.
- 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.
- Call **1-800-368-1019** (TDD: 1-800-537-7697).
- Go online at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) and fill out a complaint form at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).

## Get help in your language

One more right that you have the right to get this information in your language for free. If you'd like extra help to understand this in another language, call the Member Services number on your ID card (TTY/TDD: 711).

**Aside from helping you understand your privacy rights in another language, we also offer this notice in a different format for members with visual impairments. If you need a different format, please call the Member Services number on your ID card.**

### Language Assistance

#### ▶ Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

#### ▶ Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

#### ▶ Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

#### ▶ Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

#### ▶ Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)



## We're required by law to provide you with the following information:

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 and children, if deemed eligible by your group

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

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

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

Renewed	Canceled	Changed	When
●			<b>Your employer:</b> <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>
	●		<b>Your employer:</b> <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>
	●	<b>Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.</b>
	●	<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> <b>Your coverage will be canceled after you receive a written notice from us.</b>

## Special enrollment period

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 60 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.

Factors used to set the price of health care coverage for employers with 51-99 employees (these factors don't apply to groups with 100 or more full time employees):

- The plan selected by your employer
- Your employer's location
- The age and gender of each employee
- The number of enrolled employees
- The number of dependents enrolled by each enrollee
- The health status of the enrolled employees and their dependents
- Your employer's history

### 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 cost.

## 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 not stipulated in a court decree	The custodial parent's plan is	●	
	The noncustodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

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

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

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

## Recovering overpayments.

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

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

## What's not covered

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

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

**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, see 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:

- Acupuncture
- Holistic medicine
- Homeopathic medicine
- Hypnosis
- Aroma therapy
- Massage and massage therapy
- Reiki therapy
- Herbal, vitamin or dietary products or therapies
- Naturopathy
- 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
- Neurofeedback / Biofeedback

**Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the "What's Covered" section of your post enrollment Evidence of Coverage or Member Booklet unless otherwise required by law.

**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), physical therapist technicians, and athletic trainers.

**Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

**Charges Not Supported by Medical Records** Charges for services not described in your medical records.

**Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).

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

**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.

The following Contraceptives exclusion only pertains to groups that qualify to opt out:

**Contraceptives** Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.

**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.

**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 us.

**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.

**Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

**Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions 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 we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

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

Please see the "Clinical Trials" section of "What's Covered" of your post enrollment Evidence of Coverage or Member Booklet 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 Exercises** Orthoptics and vision therapy.

**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 keratotomy.

**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 for patients with diabetes or vascular disease.



**Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

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

**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 Workers' Compensation benefits are not available to you, 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.

**Gene Therapy** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

**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** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

#### **Home 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.

**Infertility Treatment** Testing or treatment related to infertility.

**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 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 Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

**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 when you became eligible due to age, 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 become eligible due to age, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

**Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

**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 it by law or if we approve it.

**Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

#### **Personal Care and Convenience**

- 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,
- Hypo-allergenic pillows, mattresses, or waterbeds,
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

**Private Duty Nursing** Private Duty Nursing Services, unless listed as covered in this Booklet. Your coverage does not include benefits for private duty nurses in the inpatient setting.

**Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.

**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.
- 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.
- Wilderness camps.

**Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

**Sexual Dysfunction** Services or supplies for male or female sexual problems.

**Stand-By Charges** Stand-by charges of a Doctor or other Provider.

The following Sterilization exclusion does not apply to groups that qualify to opt out:

**Sterilization** Services to reverse elective sterilization.

**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).

**Telemedicine** Non-interactive Telemedicine Services, such as audio-only telephone conversations, electronic mail message, fax transmissions or online questionnaire.

**Temporomandibular Joint Treatment** Fixed or removable appliances which 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.

#### **Vision Services**

- Eyeglass lenses, frames, or contact lenses, unless listed as covered in this Booklet.
- Safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- Plano lenses (lenses that have no refractive power).
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- Vision services not listed as covered in this Booklet.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.
- Blended lenses.
- Oversize lenses.
- Sunglasses and accompanying frames.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licenses provider.

**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.

**Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

## **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 us 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.

**Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, 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.

The following exclusion does not apply to groups that qualify to opt out:

**Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.

**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). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.

**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 us.

**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.

This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.

**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.

**Gene Therapy** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

**Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)

**Items Covered as Durable Medical Equipment (DME)**

Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood 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 and Medical Devices" 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 of the post enrollment Evidence of Coverage or Member Booklet for details.

**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 of the post enrollment Evidence of Coverage or Member Booklet.

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.

**Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immune-compromised or diabetic.

**Over-the-Counter Items** Drugs, devices and products permitted to be dispensed without a prescription and available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.

**Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.

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

**Weight Loss Drugs** Any Drug mainly used for weight loss.

These policies have 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, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for Anthem HealthKeepers and POS AdvantageOne plans: AHK-VA-HMOPOS-FIMC (2/17), AHK-VA-LG-HMOPOS-EOC (1/18), AHK-ABCBS-VA-PAP-FIMC, AHK-ABCBS-VA-LG-PAP-EOC (1/18). For KeyCare plans: KeyCare, Lumenos or POS AdvantageOne plans: ABCBS-VA-PPO-FIMC (2/17), ABCBS-VA-LG-PPO-COC (1/18), AHK-ABCBS-VA-PAP-FIMC, AHK-ABCBS-VA-LG-PAP-EOC (1/18)

If you have questions, please contact your agent, Group Administrator, or member services: Enrollment applications used for these plans: LG\_51-99\_EE\_VA 7/18 and LG\_100+\_EE\_VA 7/18. This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. or by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern.



# The legal stuff we're required to tell you

## 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 health care. To learn more about how we protect your privacy, your rights and responsibilities when receiving health care, 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 get 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 health care professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

To learn more 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.

Get the full details

Read your **Certificate of Coverage**, which spells out all the details about your plan. You can find it on [anthem.com](https://www.anthem.com).









Ready to choose your plan?

Questions?

Anthem Member Services:833-597-2358

Ready to use your plan?

**Get some extra help**

If you have questions, it's easy to get answers. Contact us through our online Message Center or call the Member Services number on your ID card.

**Anthem**   
And Its Affiliate HealthKeepers, Inc.