Choosing and using your plan

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

Pulaski County

Anthem Open Enrollment Guidebook- 2023-2024 Plan Year

Effective July 1, 2023

Anthem

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Time to choose your plan

Your trusted health partner

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

Time to choose your plan

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

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

This guide was created to help you understand our plans. It also has tips, tools, and resources that can help you reach your health and wellness goals when you become a member. Save it to help you make the most of your benefits throughout the year.

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Explore your plan options

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

KeyCare Plus 20/20%/2500

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

- You can choose a primary care doctor from the plan's network for preventive care such as checkups and screenings.
- You do not need to have a primary care doctor to see a specialist.
- When you want to see a specialist, such as an orthopedic doctor or a cardiologist, you do not need to visit your primary care doctor first for a referral. This can save you time and a copay.
- Choosing doctors and facilities in your plan's network — instead of those outside your plan's network — helps lower your costs.

KeyCare HSA 1500NE/20%/4075

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

- Once you pay your deductible, you will pay a percentage of the total cost (called coinsurance) anytime you receive care for a covered service. Your plan will cover the rest.
- All the money in your HSA rolls over from year to year, and it is yours even if you change health plans or jobs, or retire.
- The money you put into your HSA, any interest you earn, and the money you take out to pay for healthcare is tax-free.
- You can contribute up to $3,850 for an individual and $7,750 for a family.[2]
- If you are 55 or older, you can contribute an extra $1,000 a year.

How to choose a plan

- Think about your personal situation. Have your healthcare needs changed? Do you go to the doctor more often now? Are you taking a special prescription drug? Do you have any upcoming surgeries? You will want to look for benefits that fit your needs.
- Compare all the costs, including your monthly payment, deductible, coinsurance, copay, and out-of-pocket limit.
- Find out if your doctors, hospitals, and healthcare professionals are covered by the plan.
- Choose the right plan for your needs.

1 For a full list of qualified expenses for an individual, visit **qme.anthem.com**.
2 Veterans who have received medical benefits from Veterans Affairs due to a service-connected disability are eligible to receive or make HSA contributions. Visit the IRS website at irs.gov/irb/2004-33_IRB for details.

Using your plan

How to use your plan

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

How to use your plan

Register for online tools and resources

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

Sydney Health mobile app

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

Working with you:

- Reminding you about important preventive care needs.
- Planning and tracking your health goals, fitness, and rewards.
- Guiding you with insights based on your history and changing health needs.
- Empowering you with personalized resources to find and compare doctors and check costs.

Working for you:

- **Virtual chat visits** — **Sydney Health** can link you directly to doctors for virtual chat visits at low to no additional-cost.* During your appointment; the doctor will evaluate your symptoms; discuss your treatment options, and order prescriptions, if you need them.
- **Virtual video visits** — You can also use **Sydney Health** to connect with a doctor through video visits.
- **Virtual primary care** — When you need preventive care, such as wellness check-ins, lab work referrals, specialist referrals, or help with a long-term condition such as asthma, you can use Sydney Health to have a video visit with a doctor.

* Pricing based on $0 copay benefit eligibility offered through your plan.

How to use your plan

Use your ID card from your phone

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

Find a doctor in your plan

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

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

Schedule a checkup

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

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

Receive the COVID-19 vaccine or booster shot at no extra cost

A COVID-19 vaccine can help keep you, your family, and your community safe. You and your covered family members will not have to pay out-of-pocket costs for COVID-19 vaccine or booster doses. Your Anthem plan covers them.

You can visit any healthcare professional for your vaccine or booster shot, including those outside your plan's network.

Go to vaccines.gov to find COVID-19 vaccine locations near you.

How to use your plan

Access care from home in a way that works for you

- **Assess your symptoms online at no cost**. Answer questions through the **Sydney Health** intuitive Symptom Checker. It uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you visit a doctor.
- **Chat with a doctor at low to no additional-cost.**[1] **Sydney Health** can link you directly to doctors for virtual chat visits. During your appointment, the doctor can evaluate your symptoms; discuss your treatment options; and order prescriptions; if you need them.
- **Have a video visit with a doctor**. You can also use **Sydney Health** to connect with a doctor through video visits.
- **Schedule a virtual primary care appointment** for routine care and prescription refills, if needed. You can also receive a personalized care plan for chronic conditions, such as heart disease.

Where to go for care when you need it now

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

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

1 If you have a high-deductible health plan and have not met your deductible, the price of a visit will be $39, starting on the date in 2022 your plan renews.

Plan extras that support your health

Medical guidance

24/7 NurseLine — You can connect with a registered nurse who will answer your health questions wherever you are — anytime, day or night. They can help you decide where to go for care and find doctors and other healthcare professionals in your area. Call 800-337-4770.

Anthem Health Guides — Highly trained Anthem associates are like personal support guides who can help you with all your healthcare needs. They can help you connect with the right resources, stay on top of the screenings and tests you need, and find doctors. Reach a health guide by calling the number on your member ID card. You also can go to **anthem.com** to send a secure email or chat with them online.

The Autism Spectrum Disorder Program — This program focuses on building a strong support system for the entire family. A specialized team of clinicians will work with you to create a customized care plan, help coordinate care, and connect you with resources in your community. Call **844-269-0538**.

Emotional well-being resources — Your emotional well-being is an important part of your overall health. Emotional well-being resources, administered by Learn to Live, can help you identify the thoughts and behavior patterns that affect your emotional well-being — and work through them with online programs and personalized coaching. You will learn effective ways to manage stress, depression, anxiety, and sleep issues.

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

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

Diabetes Prevention Program — This 12 month program can help you lose weight and lower your risk of developing type 2 diabetes. Anthem and Lark have come together to offer you this program at no extra cost, it's part of your health plan. The program is customized based on your lifestyle and you will receive 24/7 coaching to provide you with tools for healthier habits to reduce your risk. You will even receive a free smart scale when you enroll and a free Fitbit2.* To see if you qualify go to enroll.lark.com/anthem.

*For participants who actively engage with Lark every week for two months by weighing in, completing missions with your coach, and logging activity and meals. Lark will notify you when you are eligible to redeem your free Fitbit.

Healthy living

MyHealth Advantage — There is no cost for this service, and it can help you stay healthy and save money. You will receive reminders when you need to refill a prescription or have a checkup, test, or exam. You will also receive a personalized and confidential MyHealth Note in the mail or on the **Sydney Health** mobile app if we see something that might help you.

Understanding healthcare terms

Deductible:

A set amount you pay each year for covered services before your plan starts to pay for covered healthcare costs.

You can use your HSA/FSA/HRA toward your deductible.

Copay:

A flat fee you pay for covered services, such as doctor visits.

Coinsurance:

Once you've met your deductible, you and your health plan share the cost of covered healthcare 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 will pay.

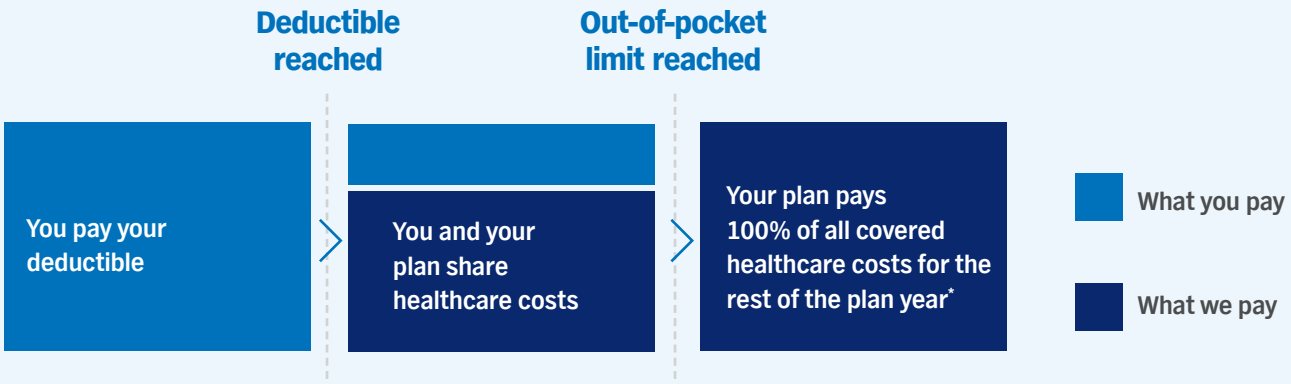
Out-of-pocket limit:

This is the maximum amount you could pay before your plan starts to pay 100% of all covered healthcare costs.* It's the sum of the deductible and coinsurance amounts.

Premium:

The premium, also called a monthly payment, is what you pay for the plan. It's the money that comes out of your paycheck.

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 receive, and the doctor you choose. Refer to your plan details to see your actual share of the cost.

* There are plans that require you to pay a copay at the time of service.

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/fi. 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/ or call (833) 592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/person or $0/family for In-Network Providers. $750/person or $1,500/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary Care Specialist Visit Preventive Care for In-Network Providers. Tier 1 Tier 2 Tier 3 Tier 4 Prescription Drugs for In-Network and Non-Network Providers. Vision for In-Network and Non-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500/person or $5,000/family for In-Network Providers. $3,750/person or $7,500/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (833) 592-9956 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan

		pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	PCP $20/visit EPHC $10/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	$40/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No charge X-Ray – Office 20% coinsurance	Lab – Office 30% coinsurance X-Ray – Office 30% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	$300/service	30% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$10/prescription (retail and home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	For more information, refer to "Base (National) Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section *Preventive RX Enhanced 2023 List covered at 100% cost-share with no copay.*
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	$30/prescription (retail) and $60/prescription (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$50/prescription (retail) and $150/prescription (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	$50/prescription (retail)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300/visit	30% coinsurance	Costs may vary by site of service.
	Physician/surgeon fees	$40/visit	30% coinsurance	Costs may vary by site of service.
If you need immediate medical attention	Emergency room care	$250/visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$40/visit	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$300/day to a maximum of $1,500/admission	30% coinsurance	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	$40/visit	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $20/visit Other Outpatient $150/visit	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	$300/day to a maximum of $1,500/admission	30% coinsurance	--------none--------
If you are pregnant	Office visits	$300/pregnancy	30% coinsurance	One copayment per pregnancy for both office visits and childbirth/delivery professional services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$300/pregnancy	30% coinsurance	
	Childbirth/delivery facility services	$300/day to a maximum of $1,500/admission	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	Rehabilitation services	$20/visit	30% coinsurance	Costs may vary by site of service. *See Therapy Services section.
	Habilitation services	$20/visit	30% coinsurance	
	Skilled nursing care	$300/day to a maximum of $1,500/admission	30% coinsurance	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	30% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	Reimbursed Up to $30	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Pediatric)
- Dental Check-up
- Glasses for a child
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care unless medically necessary
- Weight loss programs

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

- Chiropractic care 30 visits/benefit period
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 100 visits/benefit period combined with Home Health

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

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

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

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

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

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

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

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

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

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

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

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

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	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$300
Other *coinsurance*	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$70
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$830**

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

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$300
Other *coinsurance*	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$300
Other *coinsurance*	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield | Pulaski County and Public Schools

Your Contract Code: 3REA | 07/01/2023 – 06/30/2024

Your Plan: Anthem KeyCare Plus 20/20%/2500 Rx $10/$30/$50/50 w/ PreventiveRX Enhanced @ 100%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person / $0 family	$750 person / $1,500 family
Out-of-Pocket Limit	$2,500 person / $5,000 family	$3,750 person / $7,500 family
The family out-of-pocket maximum is embedded, meaning the cost shares of one family member will be applied to the per person out-of-pocket maximum; in addition, amounts for all covered family members apply to the family out-of-pocket maximum. No one member will pay more than the per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	**Preferred PCP** $10 copay per visit **PCP** $20 copay per visit	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$20 copay per visit	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	$40 copay per visit	30% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	No charge	
Specialist Care	$40 copay per visit	
Visits in an Office		
Primary Care (PCP)	**Preferred PCP** $10 copay per visit **PCP** $20 copay per visit	30% coinsurance after medical deductible is met
Specialist Care	$40 copay per visit	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$300 copay per pregnancy	30% coinsurance after medical deductible is met
Retail Health Clinic	$20 copay per visit	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$20 copay per visit	30% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	$10 copay per visit	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Dialysis/Hemodialysis	20% coinsurance	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance	30% coinsurance after medical deductible is met
Surgery	$40 copay per surgery	30% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance	30% coinsurance after medical deductible is met
Outpatient Hospital	$300 copay per service	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	$40 copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
Ambulance	20% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit	30% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	$300 copay per visit	30% coinsurance after medical deductible is met
Doctor Services	$20 copay per visit	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
Freestanding Surgical Center	$150 copay per visit	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	$40 copay per visit	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$300 copay per day to a maximum of $1,500 per admission	30% coinsurance after medical deductible is met
Doctor and other services	$40 copay per visit	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance	30% coinsurance after medical deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	$20 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after medical deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$40 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	$300 copay per day to a maximum of $1,500 per admission	30% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Drugs not included on the National drug list will not be covered. Your plan uses the Base (National) Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. PreventiveRX Enhanced 2023 List drugs covered at 100% cost-share with no copay.*		
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service. Home Delivery is an optional service on this plan.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail and home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$30 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $150 copay per prescription, deductible	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	does not apply (home delivery)	
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	$50 copay per prescription, deductible does not apply (retail only, no multi-month home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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

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

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/fi. 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/ or call (833) 592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500/person or $3,000/family for In-Network Providers. $1,500/person or $3,000/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care for In-Network Providers. Vision for In-Network and Non-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,075/person or $8,150/family for In-Network Providers. $10,000/person or $20,000/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (833) 592-9956 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral	No.	You can see the specialist you choose without a referral.

to see a specialist?		

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	20% coinsurance	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$10/prescription (retail and home delivery)	40% coinsurance (retail) and Not covered (home delivery)	For more information, refer to "Base (National) Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section **PreventiveRX Enhanced 2023 List medications covered with no member cost share before deductible.*
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	$30/prescription (retail) and $60/prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$50/prescription (retail) and $150/prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	$50/prescription (retail)	40% coinsurance (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	20% coinsurance	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	150 days/benefit period for Inpatient rehabilitation and

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				skilled nursing services combined.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	20% coinsurance	40% coinsurance	--------none--------
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period.
	Rehabilitation services	20% coinsurance	40% coinsurance	Costs may vary by site of service. *See Therapy Services section.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	40% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	Reimbursed Up to $30	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

- Acupuncture
- Dental care (Adult)
- Glasses for a child
- Long-term care
- Bariatric surgery
- Dental care (Pediatric)
- Hearing aids
- Routine foot care unless medically necessary
- Cosmetic surgery
- Dental Check-up
- Infertility treatment
- Weight loss programs

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

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 • Routine eye care (Adult) 1 exam/benefit period	• Most coverage provided outside the United States. See www.bcbsglobalcore.com	• Private-duty nursing 100 visits/benefit period in a Home Setting only

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

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

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

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

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

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

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	$1,400
Specialist *coinsurance*	20%
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$10
Coinsurance	$2,075
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,545**

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

The plan's overall deductible	$1,400
Specialist *coinsurance*	20%
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

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

The plan's overall deductible	$1,400
Specialist *coinsurance*	20%
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield | Pulaski County and Public Schools

Your Contract Code: 3REB | 07/01/2023 – 06/30/2024

Your Plan: Anthem HSA 1500NE/20%/4075 Rx $10/$30/$50/$50 w/ Preventive RX Enhanced @ 100%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$1,500 person / $3,000 family
Out-of-Pocket Limit	$4,075 person / $8,150 family	$10,000 person / $20,000 family
The family deductible and out-of-pocket maximum are non-embedded, meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The per person deductible and per person out-of-pocket maximum only apply to individuals enrolled under single coverage. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	20% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred Reference Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility Visit		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the National drug list appear below. Drugs not included on the National drug list will not be covered. Your plan uses the Base (National) Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. Preventive RX Enhanced 2023 list covered at 100% before deductible.*		
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service. Home Delivery is an optional service on this plan.*		
PreventiveRX Plus Medications	No charge	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription after deductible is met (retail and home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$30 copay per prescription after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	(retail) and $60 copay per prescription after deductible is met (home delivery)	(retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$50 copay per prescription after deductible is met (retail) and $150 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	$50 copay per prescription after deductible is met (retail only)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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

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

PreventiveRx Enhanced Drug List
Expanded Plan (National Drug List)

Anthem

PreventiveRx covers drugs that may keep you healthy because they may prevent illness and other health conditions. You can get the products on this list at low or no cost to you depending on your benefit.

This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

Brand-name drugs that have a generic equivalent available are not covered under this PreventiveRx benefit.

Not all drugs on this list may be covered by your plan. Some drugs, such as those used for cosmetic purposes, may be excluded from your benefits. Please refer to your Certificate or Evidence of Coverage for coverage limitations and exclusions.

BIRTH CONTROL
All generic versions are included.
Annovera
Balcoltra
Falessa Kit
Lo Loestrin 1-10-10
Natazia
Nextstellis
Slynd
Twirla
Tyblume

BLOOD CLOTS
Bevyxxa
Brilinta
Eliquis
enoxaparin
fondaparinux
Fragmin
heparin
jantoven
warfarin
Xarelto

BOWEL PREP (LAXATIVES)
Clenpiq
gavilyte
Golytely packet
peg 3350/electrolytes
peg-3350, sodium sulf, NaCl
peg-prep kit
Plenvu
Prepopik
sodium/potas sol magnesium
Trilyte

BREAST CANCER
anastrozole
exemestane
letrozole
Soltamox
tamoxifen citrate
toremifene citrate

DIABETES
Diabetic supplies - glucometers/test strips (Roche and Lifescan products only), lancets, control solutions, pen needles, insulin syringes. These products require a prescription to be covered by this plan.
acarbose
ActoPlusMet XR
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
Avandia
chlorpropamide
Cycloset
Farxiga
glimepiride
glipizide
glipizide er/xl
glipizide with metformin hcl
glyburide
glyburide with metformin hcl
glyburide, micronized
Glyxambi
Humalog
Humulin
Insulin Lispro
Insulin Lispro Protamine
Janumet
Janumet XR
Januvia
Jardiance
Korlym
Lantus
Levemir
Lyumjev
metformin hcl
metformin hcl er (generic Glucophage XR)
miglitol
nateglinide
Ozempic
pioglitazone
pioglitazone-glimepiride
pioglitazone-metformin
repaglinide
repaglinide/metformin
Rybelsus
Semglee
Soliqua
Symlin
Synjardy
Synjardy XR
tolazamide
tolbutamide
Toujeo
Tresiba
Trijardy XR
Trulicity
Victoza
Xigduo XR
Xultophy

FLU
oseltamivir
Relenza
Xofluza

GOUT
allopurinol
colchicine tablet
Duzallo
febuxostat
Gloperba
probenecid
probenecid/colchicine
Zurampic

HEART HEALTH AND HIGH BLOOD PRESSURE
acebutolol hcl
acetazolamide
afeditab cr
Aldactazide 50-50mg
aliskiren
amiloride hcl
amiloride/hctz
amlodipine besylate
amlodipine/benazepril
amlodipine/olmesartan
amlodipine/valsartan
amlodipine/valsartan/hctz
Aspruzyo
atenolol
atenolol/chlorthalidone
benazepril hcl
benazepril hcl/hctz
betaxolol hcl
bisoprolol fumarate
bisoprolol fumarate/hctz
bumetanide
Byvalson
candesartan
candesartan/hctz
captopril
captopril/hctz
Cardizem LA 120mg
Carospir
cartia xt
carvedilol
carvedilol er
chlorothiazide
chlorthalidone
clonidine hcl
Corzide
digitek
digoxin
Dilatrate SR
dilt xr
diltiazem hcl
diltiazem hcl cd, er

Diuril
doxazosin mesylate
Dutoprol
Edarbi
Edarbyclor
enalapril maleate
enalapril/hctz
eplerenone
eprosartan
ethacrynic acid
felodipine er
fosinopril sodium
fosinopril/hctz
furosemide
Gonitro
guanfacine hcl
Hemangeol
hydralazine hcl
hydrochlorothiazide
indapamide
Inderal XL
Innopran XL
irbesartan
irbesartan/hctz
isosorbide dinitrate
isosorbide dinitrate er
isosorbide dinitrate/ hydralazine
isosorbide mononitrate
isosorbide mononitrate er
isradipine
Kapspargo sprinkle
Katerzia
labetalol hcl
Lanoxin 0.1875mg
lisinopril
lisinopril/hctz
losartan
losartan/hctz
matzim LA
methazolamide
methyclothiazide
methyldopa
methyldopa/hctz
metolazone
metoprolol succinate er
Metoprolol succinate/hctz ER
metoprolol tartrate
metoprolol/hctz
minitran
minoxidil
moexipril hcl
moexipril/hctz
nadolol
nadolol/ bendroflumethiazide
nebivolol
nicardipine hcl
nifedipine
nifedipine er
nimodipine
nisoldipine
Nitro-Bid
Nitro-Dur 0.3, 0.8mg/hr
nitroglycerin, dis, sl, spr
Nitromist
nitro-time
Nymalize
olmesartan
olmesartan/amlodipine/ hctz
olmesartan/hctz
perindopril
pindolol
prazosin hcl
Prestalia
propranolol hcl
propranolol hcl er
propranolol/hctz
Qbrelis
quinapril hcl
quinapril/hctz
ramipril
ranolazine er
sorine
sotalol hcl
sotalol hcl af
Sotylize
spironolactone
spironolactone/hctz
taztia XT
Tekturna HCT
telmisartan
telmisartan/amlodipine
telmisartan/hctz
terazosin hcl
tiadylt
timolol maleate
torsemide
trandolapril
trandolapril/verapamil
triamterene
triamterene/hctz
valsartan
valsartan/hctz
Valsartan Soln
Vecamyl
verapamil hcl
verapamil hcl er, sr

HIGH CHOLESTEROL
atorvastatin
atorvastatin/amlodipine
cholestyramine
cholestyramine light
colesevelam hcl
colestipol hcl
ezetimibe
ezetimibe/simvastatin
fenofibrate (generic)
fenofibrate acid (generic)
fenofibrate micronized (generic)
fenofibrate, choline (generic)
fluvastatin
gemfibrozil
icosapent
lovastatin
niacin ER
niacor
omega-3-acid cap 1gm
pravastatin
prevalite
rosuvastatin
simvastatin
triklo

MALARIA
Arakoda
atovaquone/proguanil
chloroquine
hydroxychloroquine
mefloquine hcl
primaquine
pyrimethamine
quinine sulfate capsule

NAUSEA, VOMITING
Akynzeo
Anzemet
aprepitant
Bonjesta
Cesamet
chlorpromazine hcl
Compro
dimenhydrinate
dronabinol
doxylamine/pyridoxine
Emend sus
fosaprepitant
granisetron hcl
ondansetron hcl
ondansetron odt
palonosetron hcl
phenadoz
prochlorperazine
promethazine hcl
Sancuso
scopolamine patch
Syndros
Tigan inj
trimethobenzamide hcl
Varubi
Zuplenz

OSTEOPOROSIS
alendronate sodium
Alora
amabelz
Angeliq
Binosto
calcitonin
Climara Pro
Combipatch
dotti
Duavee
estradiol tab, patch
estradiol/norethindrone acetate
estropipate
Forteo
fortical
Fosamax Plus D
fyavolv
ibandronate
jenatique lo
jinteli
lopreeza
lyllana
medroxyprogesterone acetate
Menest
Menostar
mimvey lo
mimvey
norethindrone acetate/ ethinyl estradiol

Prefest
Premarin tablets
Premphase
Prempro
Prolia
raloxifene
risedronate
Tymlos
zoledronic acid (generic Reclast)

RSV (RESPIRATORY SYNCYTIAL VIRUS)
Synagis

STOPPING SMOKING
APO-varenicline
bupropion hcl sr (generic Zyban only)
Nicotrol inhaler
Nicotrol NS
varenicline

STROKE
aspirin/dipyridamole
aspirin/omeprazole
cilostazol
clopidogrel bisulfate
dipyridamole
Durlaza ER
prasugrel
Yosprala
Zontivity

VACCINES
All brand and generic versions are included.

VITAMINS
All generic versions are included.

Prenatal vitamins (taken during pregnancy)
Prescription multivitamins with fluoride
Prescription multivitamins with fluoride and iron

WEIGHT LOSS
Belviq, XR
benzphetamine hcl
diethylpropion hcl
diethylpropion hcl er
Lomaira
orlistat
phendimetrazine
phentermine hcl

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

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

Spanish
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)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TDD/TTY: 711)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehjí niká a'doowoł t'áá jiik'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

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

Anthem

When you need care quickly

Knowing where to go can save you time and money

When you need care right away, the emergency room (ER) might be the first place that comes to your mind. However, the ER may not be the best choice in every situation. You have options when you have a sudden need for care, and knowing what they are can help you save time and money — and feel better sooner.

Where to go for care

Going to the ER or calling 911 is always your best option for emergencies. If it's not an emergency, you can see your primary care physician (PCP), have a virtual visit with a doctor, or go to a retail health clinic or urgent care center. This chart compares those options:[1]

PCP	Virtual care	Retail health clinic	Urgent care center	Emergency room
Usually available during normal business hours and may also provide medical advice by phone after hours	24/7 access to doctors through the **Sydney Health**℠ app, no appointment needed	Walk-in care clinics located in certain drugstores and major retailers	Stand-alone facilities, open extended hours	Stand-alone facilities or part of hospitals, open 24/7
cost[7] **$$** / average wait[2] **18 min**	cost **$** / average wait[3] **10 min**	cost **$$** / average wait[4] **30 min**	cost **$$$** / average wait[5] **30 min**	cost **$$$$** / average wait[6] **90 min**
Mild asthma, back pain, flu-like symptoms, allergies, fever, sprains, diarrhea, eye or sinus infection, rash, urinary tract infection (UTI), sore throat, earaches, bumps, minor cuts and scrapes, and other nonemergency symptoms	Flu-like symptoms, allergies, fever, sinus pain, diarrhea, eye infection, rash, UTI	They help ensure tests Sore throat, earaches, bumps, minor cuts and scrapes, UTI	Sprain and strains, nausea, diarrhea, ear or sinus pain, minor allergic reactions, cough, sore throat, minor headache, UTI	Signs of a heart attack (chest pain) or stroke (sudden numbness and slurred speech), difficulty breathing, and severe burn or bleeding – and any other symptoms where it is reasonable to think you are having a life-threatening emergency or your health is in serious jeopardy

How to find the care you need:

1. Go to **anthem.com or download the Sydney Health mobile app from the App Store® or Google Play™.** Then, log in to:
   - Find a doctor if you don't have a PCP.
   - Have a virtual visit with a doctor using the Sydney Health℠ mobile app.
   - Find a retail health clinic, urgent care center, or ER.
2. Choose **Find Care** and follow the steps.

Did you know?

The average total cost of an ER visit can be up to **10 times** more than an urgent care center visit. ER wait time is usually about **three times** more than at an urgent care center.[8]

Learn more about your healthcare options

Use your phone's camera to scan this QR code.

Anthem®

Sources:
1 The care options and list of symptoms are not all-inclusive. If possible, consult your PCP for more guidance.
2 Business Wire: *9th Annual Vitals Wait Time Report Released* (accessed July 2021): businesswire.com.
3 LiveHealth Online, internal data 2020.
4 Healthcare Finance: *Patient wait times show notable impact on satisfaction scores, Vitals study shows* (accessed July 2021): healthcarefinancenews.com.
5 Urgent Care Association: *UCA 2019 Benchmarking Report* (accessed July 2021): ucaoa.org.
6 Harvard Business Review: *To Reduce Emergency Room Wait Times, Tie Them to Payments* (accessed July 2021): hbr.org.
7 Costs are ranked according to the member's estimated out-of-pocket costs and average health plan copays. Each plan may have different costs. Nonemergency care outside of your network may cost more out of pocket or may not be covered at all. $ = lower cost, and $$$ = higher cost. Call the Member Services number on your ID card if you have questions about your plan.
8 Healthgrades: *Should You Go to the ER or Urgent Care? How to Decide* (accessed July 2021): healthgrades.com.

Stay on top of your health

Use your preventive care benefits

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

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

Preventive care vs. diagnostic care

What's the difference? Preventive care helps protect you from getting sick. If your doctor recommends you receive services even though you have no symptoms, that's preventive care. Diagnostic care is when you have symptoms and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

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

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

Women's preventive care:

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

Immunizations:

- Coronavirus disease (COVID-19)
- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles)

The preventive care services listed above are recommendations of the Affordable Care Act (ACA) and therefore are subject to change. They may not be right for every person. Ask your doctor what's right for you.

43199MUMHCABS BV 03/22

Child preventive care

Preventive physical exams, screenings, and tests:

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

Immunizations:

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

Coverage for pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules.
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network.
- Have prescriptions, even for OTC items.

Adult preventive drugs and other pharmacy items (age appropriate):

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease (CVD), preeclampsia, and colorectal cancer in adults younger than age 70
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for those ages 18 and older

Child preventive drugs and other pharmacy items (age appropriate):

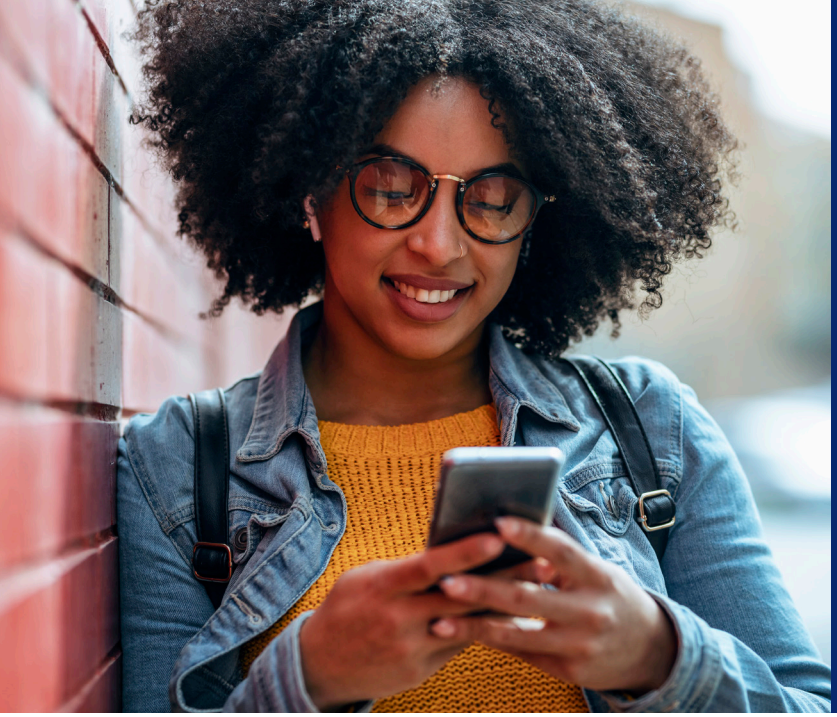
- Dental fluoride varnish to prevent tooth decay in children ages 5 and younger
- Fluoride supplements for children ages 6 and younger

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

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

If you'd like more help understanding your preventive care benefits, call the number on the back of your member ID card. For a complete list of covered preventive drugs under the Affordable Care Act, view the *Preventive ACA Drug List* flyer, available at anthem.com/pharmacyinformation.

1 The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your *Certificate of Coverage* or call the Member Services number on your ID card.
2 You may be required to receive preapproval for these services.
3 The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.
4 Some plans cover additional vision services. Please see your contract or *Certificate of Coverage* for details.
5 Check your medical policy for details.
6 Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.
7 This benefit also applies to those younger than age 19.
8 Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay, or coinsurance). Contact the provider to see if such services are available.



Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

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

Find Care

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

My Health Dashboard

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

Chat

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

Virtual Care

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

Community Resources

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

Download the Sydney Health app today

Use the app anytime to:

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

Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/register to access most of the same features from your computer.

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

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

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When you're not feeling well, Sydney Health can help

Check your symptoms and connect with a doctor through the app

The Sydney Health mobile app is a quick and convenient way to assess your symptoms when you're sick and connect with a doctor, wherever you are.

Assess your symptoms

Start with the Symptom Checker and answer a few questions about how you are feeling. You'll receive information and advice tailored to your gender, age, and medical history. The Symptom Checker was built with doctors and medical professionals. It intuitively uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you even see a doctor.

Connect with a doctor

The app can connect you to a board-certified doctor through a Virtual Text Visit or Video Visit right from your phone or tablet.

Virtual Text Visits offer the convenience and privacy of texting with a qualified doctor anytime, anywhere. Through a Virtual Video Visit, the doctor will be able to see what you're experiencing and diagnose your symptoms. They can talk about your treatment options and order prescriptions and labs, as needed. They can also let you know whether you need an in-person visit as a next step.

Save money

The Sydney Health Symptom Checker is free. Virtual Text Visits cost less than most copays, at $39 or less per visit depending on your plan. Virtual Video Visits through LiveHealth Online are $59 or less, depending on your plan.

Download the free Sydney Health mobile app today. You'll be able to check your symptoms when you're sick and connect to care directly from your mobile device.

GET IT ON Google Play

Download on the App Store

Anthem

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The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

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

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

Renewed	Canceled	Changed	When
●			Your employer: ○ Keeps its status as an employer. ○ Stays in our service area. ○ Meets our guidelines for employee participation and premium contribution. ○ Pays the required health care premiums. ○ Doesn't commit fraud or misrepresent itself.
	●		Your employer: ○ Makes a bad payment. ○ Voluntarily cancels coverage (30-days advance written notice required). ○ Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan. ○ Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	●		○ We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice). ○ We decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		●	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
●		○ Stay eligible for your employer's coverage. ○ Pay your share of the monthly payment (premium) for coverage. ○ Don't commit fraud or misrepresent yourself.
	●	Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.
	●	○ Lose your eligibility for coverage. ○ Don't make required payments or make bad payments. ○ Commit fraud. ○ Are guilty of gross misbehavior. ○ Don't cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries). ○ Let others use your ID card. ○ Use another member's ID card. ○ File false claims with us. Your coverage will be canceled after you receive a written notice from us.

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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

Determining the primary and secondary plans

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

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

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

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

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

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

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

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

t) Neurofeedback / Biofeedback.

5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) unless Medically Necessary.

6) **Autopsies** Autopsies and post-mortem testing unless requested by us as stated in "Physical Examinations and Autopsy" in the "General Provisions" section.

7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

8) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

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

10) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services. The exception to this exclusion is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section.

11) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

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

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

13) **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

14) **Compound Drugs** Compound Drugs unless all of the ingredients are FDA approved*,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

15) **Contraceptives** Contraceptive devices including diaphragms, intrauterine devices (IUDs), and implants. (Added when contraceptives are excluded via a qualified religious exemption)

16) **Contraceptive Devices** Contraceptive devices including intrauterine devices (IUDs) and implants. (Added when contraceptive devices are excluded via partial religious exemption)

17) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to:

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

b) Surgery or procedures to correct congenital abnormalities that cause Functional Impairment.

c) Surgery or procedures on newborn children to correct congenital abnormalities.

18) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

19) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

20) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

21) **Delivery Charges** Charges for delivery of Prescription Drugs.

22) **Dental Devices for Snoring** Oral appliances for snoring.

23) **Dental Treatment** Dental treatment, except as listed below.

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

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

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

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

24) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

25) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.

26) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

27) **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

28) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

29) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

30) **Emergency Room Services for non-Emergency Care** Services provided in an emergency room that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

31) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

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

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

32) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.

33) **Eye Exercises** Orthoptics and vision therapy.

34) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

35) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.

36) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

    This Exclusion does not apply to the treatment of corns, calluses, and care of toenails when the services are medically necessary.

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

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

39) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

40) **Free Care** Services you would not have to pay for if you didn’t have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers’ Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

41) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

42) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

43) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

44) **Home Health Care**

a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

b) Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.

45) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

46) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).

47) **Infertility Treatment** Testing or treatment related to infertility. (Replaced with "**Infertility Treatment** Infertility procedures not specified in this Booklet" when Infertility Rider is included)

48) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

49) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

50) **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.

51) **Medical Equipment, Devices, and Supplies**

a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

c) Non-Medically Necessary enhancements to standard equipment and devices.

d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.

e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

f) Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.

52) **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

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

54) **Non-approved Drugs** Drugs not approved by the FDA.

55) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.

56) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

57) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional

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

58) **Off label use** Off label use, unless we must cover it by law or if we approve it.

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

60) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care**,** Urgent Care, or Authorized Services. (Applicable to EPO products only)

61) **Personal Care, Convenience and Mobile/Wearable Devices**

   a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

   b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

   c) Home workout or therapy equipment, including treadmills and home gyms,

   d) Pools, whirlpools, spas, or hydrotherapy equipment,

   e) Hypoallergenic pillows, mattresses, or waterbeds,

   f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

   g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

62) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.

63) **Prosthetics** Prosthetics for sports or cosmetic purposes.

64) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center**.** This Exclusion includes procedures, equipment, services, supplies or charges for the following:

   a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

   b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

   c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

66) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.

67) **Services Received Outside of Virginia** Services received from a Provider outside of Virginia. This does not apply to:

a) Emergency or Urgent Care; or

b) Covered Services approved in advance by Anthem. (Applicable to EPO products only)

68) **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance. (Applicable to EPO products only)

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

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

71) **Sterilization** Services to reverse elective sterilization. (Replaced with "**Sterilization** For female sterilization or reversal of sterilization." When there is a qualified religious exemption)

72) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

73) **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

74) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

75) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

76) **Vision Services**

a) Eyeglass lenses, frames, or contact lenses, unless listed as covered in this Booklet.

b) Safety glasses and accompanying frames.

c) For two pairs of glasses in lieu of bifocals.

d) Plano lenses (lenses that have no refractive power).

e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.

f) Vision services not listed as covered in this Booklet.

g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.

h) Blended lenses.

i) Oversize lenses.

j) Sunglasses and accompanying frames.

k) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.

l) For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.

m) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.

77) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

78) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

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

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

80) **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

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

   If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
5. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA approved, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law. (Added when contraceptives are excluded via a qualified religious exemption)
7. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
8. **Delivery Charges** Charges for delivery of Prescription Drugs.
9. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy

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

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

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

24. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
25. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
26. **Non-approved Drugs** Drugs not approved by the FDA.
27. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
28. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
29. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

    The exception to this Exclusion is described in "Covered Prescription Drugs" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.
30. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
31. **Over-the-Counter Items** Drugs, devices and products permitted to be dispensed without a prescription and available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.
32. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
33. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
34. **Weight Loss Drugs** Any Drug mainly used for weight loss.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

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

Protecting your privacy

How we keep your information safe and secure

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

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

How we help manage your care

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

For additional information about how we help manage your care, go to **anthem.com/memberrights**. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

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

- **If you had another health plan that was canceled**. If you, your dependents, or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.
- **If you have a new dependent**. You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes**. You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible..
  - You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

It's important we treat you fairly

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For full details, read your plan document, which has all the details about your plan. You can it find on **anthem.com**.

Notes

Notes

Notes

Your plan is here for you to use

If you would like extra help

Anthem Health Guides are here to help you make the most out of your medical plan. These highly trained Anthem associates will help you with all your health care needs.

Reach a health guide by calling the number on your member ID card. You also can go to **anthem.com** to send a secure email or chat with them online.

Anthem

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