2025 open enrollment

Your guide to your health plan and benefits

Anthem Open Enrollment Guidebook 2025-2026 Plan Year

Pulaski County & Schools

July 1, 2025

Anthem

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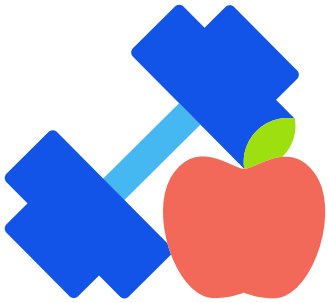
This guide is for informational purposes only. You must enroll in a plan for your benefits to start.

Welcome to Anthem

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

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

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



Why Anthem

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

The nation's largest network

Anthem gives you access to more than 1.7 million doctors and hospitals — the nation's largest network of care providers, which touches every ZIP code in the U.S.[2]

No- or low-cost preventive care

Your plan covers preventive care at little or no added cost when you see a doctor in your plan's network. Preventive care, such as your annual physical, vaccinations, and screenings, can help you stay healthy and catch issues early when they're easier to treat.

Convenient virtual care

Virtual care allows you to connect directly to care from anywhere with a smartphone, tablet, or computer with a camera. You'll be able to meet with a board-certified doctor through video or chat with little to no wait time.[3-5]

Health and wellness programs

Your Anthem benefits offer access to a variety of programs, digital tools, and health guides at no added cost to help you with your individual health needs and goals.

1 Elevance Health website: *Advancing Health Together* (May 2023): .advancinghealth.elevancehealth.com.
2 Blue Cross Blue Shield Association: *About Us: The Blue Cross Blue Shield System:* bcbs.com.
3 Virtual text and video visits powered by K Health. LiveHealth Online is the trade name of Carelon Health Solutions, Inc., a separate company, providing telehealth services on behalf of your health plan.
4 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.
5 LiveHealth Online, internal data (2023).

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Table of contents

Medical plans

Review your options to find the right fit for your needs

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

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

Keycare

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

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

HSA

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

- The money in your HSA rolls over from year to year and is yours to keep, even if you change health plans or jobs, or retire.
- You can contribute up to $4,300 for an individual and $8,550 for a family. If you're 55 or older, you can contribute an extra $1,000 a year.

Healthcare terms

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

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

Copay: A set fee that you pay at a doctor's visit or when picking up a prescription.[2]

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

Find care

Use our **Find Care** tool to see if your doctors are in the plan's network by visiting **anthem.com/find-care**

1 For a full list of qualified expenses, go to anthem.com/qme.
2 There are plans that require you to pay a copay at the time of service.

Pharmacy benefits

Reliable prescription drug coverage

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

Your plan covers:

- Brand-name and generic drugs on your drug list.
- Certain preventive drugs at a more affordable or no extra cost to you.
- Most specialty drugs required to treat an ongoing health matter or serious illness.

Coverage requirements

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

- **Preapproval, also known as prior authorization:** This means Anthem needs to approve a drug before the pharmacy fills it.
- **Step therapy:** You may need to try other medicine before we can cover the one your doctor prescribed.
- **Quantity limits:** To help protect your health, your plan may limit how much medication you can receive each month.
- **Dose optimization:** If a higher strength is available, you may be able to switch from taking multiple doses to a single dose each day.
- **90-day supply:** If you take maintenance medication for ongoing conditions like asthma, diabetes, or high cholesterol, your plan may require that you set up a 90-day supply at a local pharmacy or through CarelonRx Pharmacy home delivery.

Review your drug list

Your plan includes various drug lists with details about brand-name and generic drugs.
Check the lists for your medications; if they are not covered on the list, you'll see other options.

Visit:

- **https://fm.formularynavigator.com/FBO/143/National_4_Tier_ABCBSVa.pdf**
- **https://file.anthem.com/A00526VAMENABS.1.pdf**

To understand pharmacy benefits:

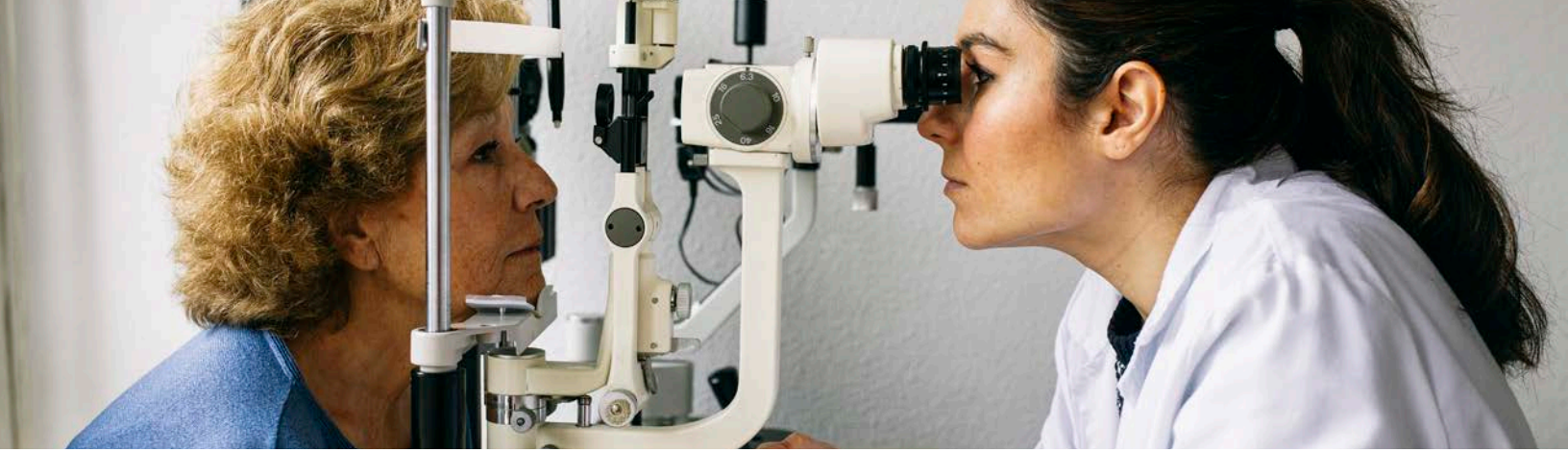
- Review your medication list to see if your prescriptions are covered.
- Price a medication to find the best price in your plan's network, which can save you more when buying certain medicines.
- Check to make sure your local retail pharmacy is in your plan's network.
- Explore home delivery with CarelonRx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

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

Your pharmacy options

You have choices for filling your prescriptions, including local retail pharmacies in your plan's network and convenient home delivery with CarelonRx Pharmacy. If you use a specialty medicine, it will need to be filled through our specialty pharmacy.

The **Base Network** is our national pharmacy network with nearly 70,000 retail pharmacies across the country. To find a pharmacy, visit **http://anthem.com/pharmacyinformation/rxnetworks.html** and choose the Base Network list.



Vision benefits

Eye care is important to your whole health

When you choose Blue View Vision, you'll be covered for routine eye exams and receive an annual allowance for eyeglasses or contact lenses. The plan features additional plan benefits to help you save even more, such as discounts on lens upgrades and extra pairs of glasses.

Save money by using an independent eye doctor, retail store, or online option that's in your plan's network. If traveling abroad, you'll have access to translation support and resources as needed.

Your vision benefits include:

- Routine adult and pediatric eye exams. A copay may apply.

If you choose contact lenses, you'll receive:

- A contact lens allowance.
- A discount off the balance if you buy conventional contact lenses that cost more than your benefit allowance.

Keep an eye on your health

Routine eye checkups go beyond making sure you're seeing clearly. They can also catch other health issues early, such as diabetes, high blood pressure, high cholesterol, and autoimmune diseases.*

* American Optometric Association: *Updated Clinical Guideline Reinforces Importance of Annual Eye Exams, Comprehensive Eye Care with Doctors of Optometry* (March 8, 2023): aoa.org.

Plan extras

Extra benefits that support your whole health

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

Condition support

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

24/7 NurseLine

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

Autism Spectrum Disorder Program

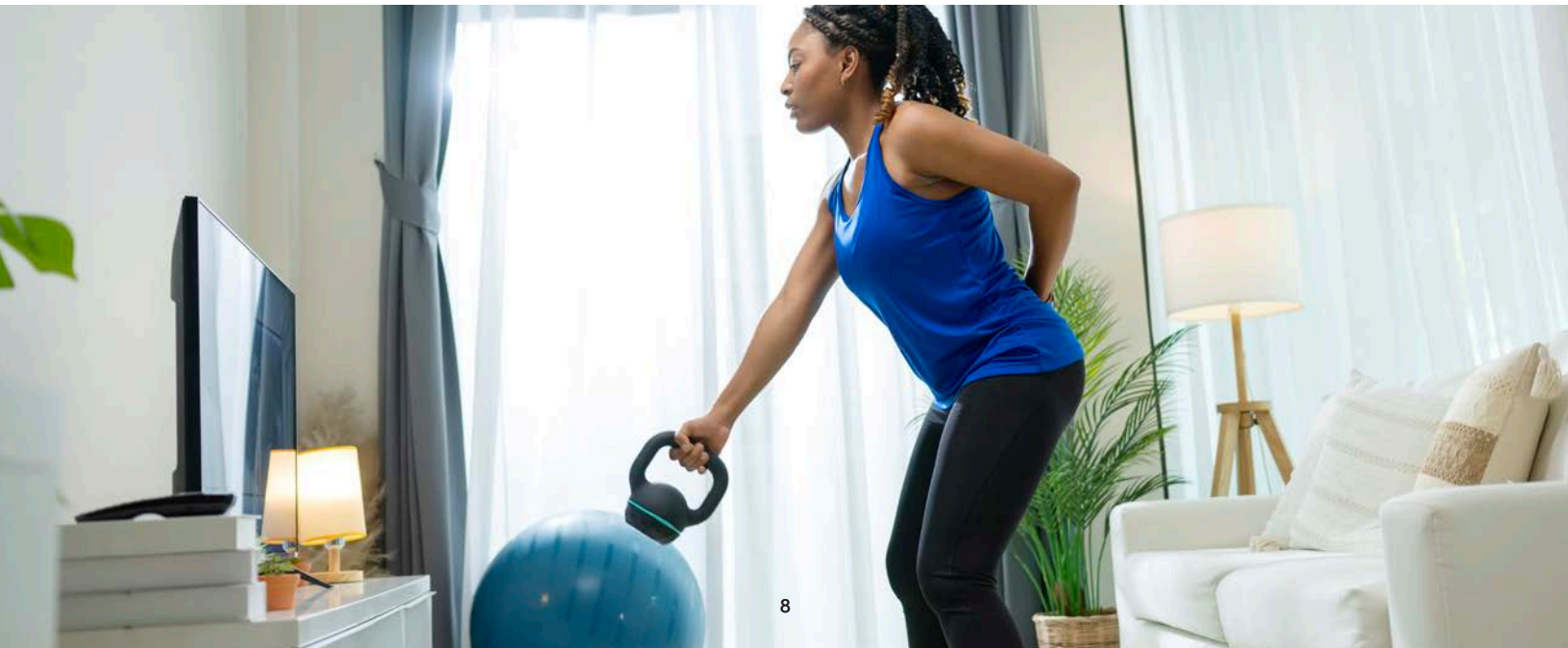
This program focuses on building a strong support system for the entire family. A specialized team of clinicians will work with you to create a customized care plan, help coordinate care, and connect you with resources in your community.

Case Management

A care management team will reach out to help you as you transition home from surgery or if you have a serious health condition. They'll answer your questions about your follow-up care, medicines, or treatment options, coordinate benefits for home therapy or medical supplies, and find community resources for you.

ConditionCare CORE

A dedicated care management team, including dietitians, health educators, and pharmacists, is available to help you learn about and manage chronic health conditions, such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, or heart failure.



ConditionCare End-Stage Renal Disease

A registered nurse will help you manage your day-to-day needs if you have end-stage renal disease (ESRD). They'll help you schedule dialysis care and doctor visits, follow your treatment plan, understand your medical equipment, and find other helpful resources and information. You don't have to do anything to take advantage of this benefit. A nurse will call you to ask if you want to enroll.

ConditionCare Vascular – at-Risk Support

If you have an increased risk of coronary artery disease, diabetes, stroke, peripheral vascular disease, or peripheral artery disease, a care management team can address your health questions anytime, day or night. They'll help you reach your health goals and provide educational guides and tools to help you learn more about your condition.

ConditionCare Musculoskeletal Support

If you have arthritis, osteoporosis, or knee or hip issues, a care management team can help address your health questions anytime, day or night. They'll help you reach your health goals and provide educational guides and tools to help you learn more about your condition.

ConditionCare Low Back Pain Support

If you have low back pain, reach out to your care management team anytime, day or night. They'll help you reach your health goals and provide educational guides and tools to help you learn more about your condition.

Diabetes Prevention Program

ABCBS offers you this 12-month program at no extra cost as part of your health plan. This prevention program can help you lose weight and lower your risk of developing type 2 diabetes. It's flexible, customized for you, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health.

Maternity

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

Building Healthy Families

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

Behavioral health

When life gets tough, it can be hard to remember you're not alone. Your Anthem health benefits include a variety of support for your mental health and emotional wellbeing, which can help you take better care of all the other things that matter in your life.

Behavioral Health

Extra support can make a difference with things like depression, anxiety, substance use, or eating disorders. Our caring professionals will work with you to arrange counseling and support services that meet your individual and family needs.

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Pulaski County and Public Schools

Your Contract Code: Custom 3REA

07/01/2025-06/30/2026

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

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	$40 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$0 person / $0 family	$750 person / $1,500 family
Overall Out-of-Pocket Limit	$2,500person / $5,000 family	$3,750 person / $7,500 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Preferred PCP *virtual and office* *(Providers reflected in our FindCare tool as: EPHC Providers)*	$10 copay per visit	Not covered
Primary Care (PCP) *virtual and office*	$20 copay per visit	30% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit	30% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$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 an Out-of-Network Provider
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	$300 copay per pregnancy	30% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$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
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
Preventive care / screenings / immunizations	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
Diagnostic Services		
Lab		
Office	No charge	30% coinsurance after medical deductible is met
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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
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
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$40 copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance	Covered as In-Network
Ambulance *Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.*	20% coinsurance	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
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
Ambulatory Surgical Center	$150 copay per visit	30% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
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 an Out-of-Network Provider
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility Fees	$300 copay per day to a maximum of $1,500 per admission	30% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	$40 copay per visit	30% coinsurance after medical deductible is met
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 and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	$20 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance	30% coinsurance after medical deductible is met
Pulmonary rehabilitation		
Office	$40 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
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Chemo/Radiation Therapy *office and 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
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 an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: *Base (National) Network* Drug List: *National Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: Retail Pharmacy *30 day supply (cost shares noted below)* Retail 90 Pharmacy *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* Home Delivery Pharmacy *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* Specialty Pharmacy *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.* *PreventiveRX Enhanced List covered at 100% cost-share with no copay.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 1 - Typically Generic	$10 copay per prescription (retail and home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$30 copay per prescription (retail) and $60 copay per prescription (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$50 copay per prescription (retail) and $150 copay per prescription (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	$50 copay per prescription, deductible does not apply (retail only, no multi-month 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 an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

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

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

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

Anthem

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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 obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
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Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
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Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, 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

Your summary of benefits

Anthem

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

Your Contract Code: Custom 3REB | 07/01/2025- 06/30/2026

Your Plan: Anthem HSA 1650NE/20%/4075 Rx $10/$30/$50/$50 w/ Preventive Rx @ 100%

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$1,650 person / $3,300 family	$1,650 person / $3,300 family
Overall Out-of-Pocket Limit	$4,075 person / $8,150 family	$10,000 person / $20,000 family
The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care *virtual and office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Other Services in an Office		
Allergy Testing	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
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
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 *Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.*	20% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
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
Ambulatory Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
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
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy *office and 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 an Out-of-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 an Out-of-Network Pharmacy**
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: *National Network* Drug List: *Base (National) Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: Retail Pharmacy *30 day supply (cost shares noted below)* Retail 90 Pharmacy *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* Home Delivery Pharmacy *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* Specialty Pharmacy *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.* *Preventive RX Enhanced 2024 list covered at 100% before deductible.*		
PreventiveRX Enhanced Plus Medications	No charge	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Tier 1 - Typically Generic	$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	$30 copay per prescription after deductible is met (retail) and $60 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Tier 3 - Typically Non-Preferred Brand	$50 copay per prescription after deductible is met (retail only)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	$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 an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or

Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.

- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

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

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

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

Anthem

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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 obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

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Japanese
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Italian
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TTY/TTD:711

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PreventiveRx Drug List
Enhanced Plan (National Drug List)

Anthem
And Its Affiliate HealthKeepers, Inc.

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.

Please note: The drug list is subject to change and all previous versions of the drug list are no longer in effect.

This list is not all-inclusive; but many examples of preventive medications in each category are listed.

ASTHMA
albuterol sulfate nebulization solution
albuterol sulfate nebulization syrup
albuterol sulfate nebulization tablets
albuterol sulfate HFA
Arnuity Ellipta
Breo Ellipta
breyna
budesonide inhalation suspension
budesonide/formoterol aerosol
cromolyn nebulization solution
elixophyllin
Flovent Diskus
Flovent HFA
fluticasone HFA
fluticasone diskus (generic for Flovent Diskus)
fluticasone/ salmeterol HFA (generic for Advair HFA)
fluticasone/ salmeterol powder (generic for Advair Diskus)
fluticasone/ salmeterol powder (generic for Airduo RespiClick)
fluticasone/ vilanterol
formoterol nebulization solution
levalbuterol nebulization solution
levalbuterol HFA
montelukast
ProAir RespiClick
QVAR RediHaler
Serevent Diskus
Spiriva Respimat
terbutaline tablets
Theo- 24
theophylline elixer
theophylline solution
theophylline ER
Trelegy Ellipta
wixela inhub
zafirlukast

BLOOD CLOTS AND STROKE
aspirin-dipyridamole ER
Brilinta
cilostazol
clopidogrel bisulfate
dipyridamole
Eliquis
heparin
jantoven
prasugrel
warfarin
Xarelto

DIABETES
{Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips for OneTouch and Accu-Chek products will be covered by this benefit. Continuous Glucose Monitors (CGMs) are not included in PreventiveRx Coverage.
acarbose
alogliptin
alogliptin/metformin
alogliptin/pioglitazone
Farxiga
glimepiride (1mg, 2 mg, 4mg)
glipizide
glipizide ER/XL
glipizide/ metformin
glyburide
glyburide micronized
glyburide/ metformin
Glyxambi
Humalog
Humalog Junior KwikPen
Humalog KwikPen
Humalog Mix 50/50
Humalog Mix 50/50 KwikPen
Humalog Mix 75/25
Humalog Mix 75/25 KwikPen
Humulin 70/30
Humulin 70/30 KwikPen
Humulin N
Humulin N KwikPen
Humulin R
Humulin R KwikPen
Insulin Glargine (100U/ml)
Insulin Glargine Solostar (100U/ml)
Insulin Lispro
Insulin Lispro Junior KwikPen
Insulin Lispro KwikPen
Insulin Lispro Protamine
Janumet
Janumet XR
Januvia
Jardiance
Lantus
Lantus SoloStar
Lyumjev
Lyumjev KwikPen
metformin (500 mg, 850 mg, 1000 mg)
metformin ER (Generic for Glucophage XR)
miglitol
Mounjaro
nateglinide
Ozempic
pioglitazone
pioglitazone/ glimepiride
pioglitazone/ metformin
repaglinide
Rybelsus
Soliqua
SymlinPen
Synjardy
Synjardy XR
Toujeo
Toujeo Max
Toujeo SoloStar
Tresiba
Tresiba Flextouch
Trijardy XR
Trulicity
Xigduo XR
Xultophy

PreventiveRx Drug List

Enhanced Plan (National Drug List)

Anthem
And Its Affiliate HealthKeepers, Inc.

HEART HEALTH AND HIGH BLOOD PRESSURE

acebutolol
acetazolamide
acetazolamide ER
aliskiren
amiloride
amiloride/ hctz
amlodipine besylate
amlodipine/ benazepril
amlodipine/ olmesartan
amlodipine/ valsartan
amlodipine/ valsartan/ hctz
atenolol
atenolol/ chlorthalidone
benazepril
benazepril/ hctz
betaxolol
bisoprolol fumarate
bisoprolol fumarate/ hctz
bumetanide
candesartan
candesartan/ hctz
captopril
captopril/ hctz
cartia XT
carvedilol
carvedilol ER
chlorthalidone
clonidine tablets
clonidine patches
digitek
digox
digoxin
diltiazem
diltiazem CD
diltiazem ER
dilt-XR
doxazosin
enalapril oral solution
enalapril tablets
enalapril/ hctz
eplerenone
ethacrynic acid tablets
felodipine ER
fosinopril sodium
fosinopril/ hctz
furosemide
guanfacine
hydralazine
hydrochlorothiazide
indapamide
irbesartan
irbesartan/ hctz
isosorbide dinitrate
isosorbide dinitrate/ hydralazine
isosorbide mononitrate
isosorbide mononitrate ER
isradipine
labetalol
levamlodipine
lisinopril
lisinopril/ hctz
losartan
losartan/ hctz
matzim LA
methazolamide
methyldopa
metolazone
metoprolol succinate ER
metoprolol tartrate
metoprolol tartrate/ hctz
minoxidil
moexipril
nadolol
nebivolol
nicardipine
nifedipine
nifedipine ER
nimodipine
nisoldipine ER
Nitro-Dur 0.3, 0.8mg/ hr
nitroglycerin
nitroglycerin 400 mcg spray
nitroglycerin sublingual tablets
olmesartan
olmesartan/ amlodipine/ hctz
olmesartan/ hctz
perindopril
pindolol
prazosin
propranolol
propranolol ER
quinapril
quinapril/ hctz
ramipril
ranolazine ER
sorine
sotalol
sotalol AF
spironolactone suspension
spironolactone tablets
spironolactone/ hctz
taztia XT
telmisartan
telmisartan/ amlodipine
telmisartan/ hctz
terazosin
tiadylt
timolol tablets
torsemide
trandolapril
trandolapril/ verapamil
triamterene
triamterene/ hctz
valsartan solution
valsartan tablets
valsartan/ hctz
verapamil
verapamil ER
verapamil SR

HEART RATE AND RHYTHM

amiodarone
disopyramide
dofetilide
flecainide
mexiletine
Norpace CR
pacerone
propafenone
propafenone ER
quinidine
quinidine CR
quinidine ER

HIGH CHOLESTEROL

atorvastatin
atorvastatin/ amlodipine
cholestyramine
cholestyramine lite
colesevelam tablets
colestipol granules
colestipol tablets
ezetimibe
ezetimibe/ simvastatin
fenofibrate (43, 50, 67, 130, 134, 150, 200 mg capsules & 48, 54, 145, 160 mg tablets)
fenofibric acid
fluvastatin
gemfibrozil
lovastatin
niacin ER
pravastatin
prevalite
rosuvastatin
simvastatin

MALARIA

atovaquone/proguanil
chloroquine
hydroxychloroquine
mefloquine
primaquine

MENTAL HEALTH

amitriptyline
amoxapine
aripiprazole
aripiprazole ODT
bupropion
bupropion SR
bupropion XL
carbamazepine
carbamazepine ER
chlorpromazine
citalopram solution
citalopram tablets
clomipramine
clozapine
clozapine ODT
desipramine
desvenlafaxine ER
Dilantin
divalproex sodium DR, ER
doxepin
duloxetine
Epitol
escitalopram
ethosuximide
felbamate

fluoxetine capsules
fluoxetine solution
fluoxetine tablets
fluoxetine DR
fluphenazine
fluvoxamine
fluvoxamine ER
gabapentin
haloperidol solution
haloperidol tablets
imipramine capsules
imipramine tablets
lacosamide
lamotrigine chewable
lamotrigine ER
lamotrigine ODT
lamotrigine tablets
levetiracetam
levetiracetam ER
lithium
lithium ER
loxapine
mirtazapine
mirtazapine ODT
molindone
nefazodone
nortriptyline
olanzapine
olanzapine ODT
olanzapine/ fluoxetine
oxcarbazepine
oxcarbazepine ER
paliperidone ER
paroxetine
paroxetine ER
perphenazine
phenelzine
phenytek
phenytoin
phenytoin chewable
phenytoin ER
phenytoin infatabs
pregabalin
primidone
prochlorperazine
protriptyline
quetiapine
quetiapine ER
risperidone ODT
risperidone solution
risperidone tablets
roweepra
sertraline tablets
subvenite
thioridazine
thiothixene
tiagabine
topiramate
topiramate ER
tranylcypromine
trazodone
trifluoperazine
trimipramine
Trintellix
valproic acid
venlafaxine
venlafaxine ER 225 mg tablets
venlafaxine ER capsules
vilazodone
ziprasidone
zonisamide

OSTEOPOROSIS
alendronate
amabelz
calcitonin- salmon
Climara Pro
Combipatch
dotti
estradiol gel
estradiol patch
estradiol tablets
estradiol/ norethindrone
Fosamax Plus D
Fyavolv
ibandronate tablets
jinteli
lyllana
medroxyprogesterone
Menest
mimvey
norethindrone-ethinyl estradiol
Premarin tablets
Premphase
Prempro
raloxifene
risedronate
risedronate DR

This list may change without notice which may affect your benefit coverage. To be sure your medication is covered under the PreventiveRx benefit, call the member services number located on your ID card.

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Blue View Vision℠
EX.A.0/15

Anthem

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at anthem.com, or the Sydney app. You may also call member services for assistance at 1-866-723-0515.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

Your vision plan includes coverage for routine eye exams

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
Routine Eye Exam For members age 19 and older.	$15 Copay	Reimbursed Up To $30	Once every calendar year
Pediatric Routine Eye Exam For members up to age 19.	$0 Copay	Reimbursed Up To $30	Once every calendar year
Contact lens fit and follow-up *A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.*			
• Standard contact lens fitting • Premium contact lens fitting	$0 Copay 10% off retail price, then apply $55 allowance	Reimbursed Up To $35 Reimbursed Up To $35	Once every calendar year

USING YOUR BLUE VIEW VISION PLAN

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

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

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

OUT-OF-NETWORK

If you choose to, you may receive covered services outside of the Blue View Vision. If you choose an out-of-network doctor, you must pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. To download a claim form, log in at anthem.com, or from the home page menu locate support and select Forms, click Change State to choose your State, and then scroll down to Claims and select the Blue View Vision Out-Of-Network Claim form. You may instead call member services at 1-866-723-0515 to request a claim form. To request reimbursement for out-of-network services, complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below:

TO FAX: 866-293-7373
TO EMAIL: oonclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at 1-866-723-0515. This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY (Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage.)		In-Network Member Cost (after any applicable copay)
Retinal Imaging - at member's option, can be performed at time of eye exam		Not More Than $39
Eyeglass Frame	When purchased as part of a complete pair of eyeglasses[1]	35% off retail price
Eyeglass Lenses Standard plastic material	• When purchased as part of a complete pair of eyeglasses[1]: - Single Vision - Bifocal Vision - Trifocal Vision	 $50 $70 $105
Eyeglass Lens Options and Upgrades When purchasing a complete pair of eyeglasses[1] (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglasses lenses.	• UV Coating • Tint (Solid and Gradient) • Standard Scratch-Resistant Coating • Standard Polycarbonate • Standard Anti-Reflective Coating • Standard Progressive Lenses (add-on- to Bifocal) • Other Add-Ons (i.e. high index lenses, anti-fog coating)	$15 $15 $15 $40 $45 $65 20% off retail price
Conventional Contact Lenses (non-disposable type)	• Discount applies to materials only	15% off retail price

[1] If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.
Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations. Some of our in-network providers include:

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at anthem.com, select discounts, then Vision, Hearing & Dental. * Discounts cannot be used in conjunction with your covered benefits.

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)**

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

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

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ ɓé m̀ ké bɔ̃ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kõɛ ɓé m̀ ké gbo-kpá-kpá dyé. **(TTY/TDD: 711)**

Bengali
িবনামূেল্য এই তথয্ পাওয়ার ও আপনার ভাষায় সাহাযয্ করার অিধকার আপনার আেছ। সাহােযয্র জনয্ আপনার আইিড কাের্ড থাকা সদসয্ পিরেষবা ন□ের কল করন। **(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)**

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)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (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)

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)

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)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔
(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)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (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.

Preventive health guidelines

Take steps toward a healthier future by making preventive care a priority. Your health plan covers certain preventive screenings, wellness exams, and vaccinations to help find potential health issues early and keep you and your family healthy.

While the following guidelines provide examples of various preventive services, they may not mention every service that's available to you. It's important to talk to your doctor about which exams, screenings, and vaccines are right for you and your family, so you can develop a personalized care plan.

These guidelines are based on recommendations and requirements from health experts, including:

- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics — Bright Futures (AAP)
- Advisory Committee on Immunization Practices (ACIP)
- American College of Obstetricians and Gynecologists (ACOG)
- American Cancer Society (ACS)
- Centers for Disease Control and Prevention (CDC)
- U.S. Preventive Services Task Force (USPSTF)

Keep in mind, coverage of preventive services varies by health plan, so your plan may not pay for all the services and screenings listed here.

To find out what your plan covers, you can:

- Visit **anthem.com.**
- Call the Member Services number on the back of your health plan ID card.
- Check your member handbook.

Anthem
And Its Affiliate HealthKeepers, Inc.

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Well-baby and well-child exams

Well-baby exam — birth to 2 years

Infants should be seen by a doctor at birth and again at the following ages, or as their doctor suggests:

- 3 to 5 days
- 2 weeks to 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months

If your child leaves the hospital less than 48 hours after birth, they need to be seen by a doctor 2 to 4 days after being born.

Well-baby visits may include a physical exam, vaccinations, and age-appropriate tests and screenings like those in the chart below. Your child's doctor may also talk to you about:

- Newborn care, safety, and development.
- Nutrition and feeding.
- Your and your family's health and well-being.
- Minimizing exposure to ultraviolet (UV) radiation.

Age to receive screening (in months)

Screening	Birth	1	2	4	6	9	12	15	18	24
Weight, length, and head measurement	At each visit									
Body mass index (BMI) percentile										At 24 months
Newborn metabolic disorders, such as PKU (the body's inability to break down protein), sickle cell (an inherited blood disorder), and thyroid issues	Bilirubin at birth (checks for newborn jaundice)									
Critical congenital heart defect (birth defects of the heart)	At birth									
Development — brain, body, and behavior	At each visit									
Hearing	Screen in the hospital after birth and at each visit.									
Vision	At each visit									
Oral/dental health							Referral to a primary care dentist, if needed, starting at 6 months. Begin yearly dental exams starting at 12 months. Fluoride varnish when teeth start coming in. Fluoride prescription based on your drinking water (from 6 to 24 months).			
Hemoglobin or hematocrit (blood count)				Check for risks.			Screen at 12 months and check for risks as the doctor suggests.			
Hepatitis B	Check for risks at each visit.									
Lead tests							At 12 and 24 months. Check for risks as the doctor suggests.			
Autism (a condition that affects communication and social skills)									At 18 months	At 24 months
Maternal postpartum depression		Screen at baby's 1, 2, 4, and 6 month visits.								
Blood pressure	Check for risks at each visit.									
Lipid disorder (cholesterol)										Check for risk at 24 months.
Tuberculosis	Check for risks and test as the doctor suggests.									

Note: Treatment with an eye ointment is recommended at birth for all infants to prevent any infection passed by the mother during delivery.

Well-baby exam — ages 2½ years to 10 years

Depending on your child's age, well-child visits may include a physical exam, vaccinations, and age-appropriate screenings like those on the chart below. Their doctor may also talk to you about:

- Promoting healthy nutrition.
- Exercise, growth, safety, and healthy habits.
- Any learning or school issues.
- Emotional and mental health.
- Family and home living issues.
- Minimizing exposure to UV radiation.

Age to receive screening (in years)

Screening	2½	3	4	5	6	7	8	9	10	11
Height, weight, and BMI percentile	Each year									
Development — brain, body, and behavior	Each year									
Vision	Each year									
Hearing	Check for risks at each visit.		Screen at each visit.							
Anxiety							Screen each year starting at age 8.			
Lipid disorder (cholesterol problems)	Check for risks each visit.							Once between ages 9 and 11		
Oral/dental issues	Dental exams each year. Fluoride varnish on the teeth when the dentist suggests (between 2 ½ and 5 years). Fluoride prescription based on your drinking water (between 2 ½ and 10 years).									
Hemoglobin or hematocrit (blood count)	Check for risks at each visit.									
Blood pressure risk assessment		Each year starting at age 3. Check for risks before age 3.								
Lead testing	Check for risks each year through age 6.									
Tuberculosis	Check for risks and test as the doctor suggests.									

Well-child to young adult exam — ages 11 to 20 years

These visits may include vaccinations and age-appropriate screenings, in addition to a full-body exam. Depending on your child's age, their doctor may also discuss:

- Growth and development, such as oral hygiene habits, body image, healthy eating, physical activity, and sleep.
- Emotional well-being, including mood control and overall mental health.
- Safe sex, especially reducing the risk of sexually transmitted infections and diseases (STIs and STDs) and unplanned pregnancy.
- Substance use, including the use of alcohol, tobacco, e-cigarettes, and prescription or illegal drugs.
- School performance.
- Family and home living issues.
- General safety, such as seat belt and helmet use.
- Firearm safety, if they are regularly around guns.
- Intimate partner violence.
- Minimizing exposure to UV radiation.

Screening	11	12	13	14	15	16	17	18	19	20
Height, weight, and BMI*	Percentile to age 19, then BMI each year									
Development — brain, body, and behavior	Each year									
Depression and suicide risk		Screen each year starting at age 12.								
Anxiety	Each year									
Blood pressure	Each year									
Vision	Each year									
Hearing	Screen with audiometry, once between ages 11 and 14, once between ages 15 and 17, and once between ages 18 and 21.									
Oral/dental health	Referral to a dentist each year. Fluoride prescription based on your drinking water (ages 11 to 16).									
Hemoglobin or hematocrit (blood count)	Check for risks each year.									
Gonorrhea and chlamydia	Screen each year starting at age 11, if sexually active.									
Syphillis	Screen in those at increased risk of infection.									
Human immunodeficiency virus (HIV)					Once between 15 and 18. Those younger than 18 should be screened if they have risk factors for HIV infection. Those at higher risk should be offered pre-exposure prophylaxis (PrEP).					
Lipid disorder (cholesterol)	Screen once between ages 9 and 11.	Check for risks each year.					Screen once between ages 17 and 21.			
Substance use disorder and tobacco addiction	Check for risks each year.									
Tuberculosis	Check for risks each year and test as your doctor suggests.									
Hepatitis C	Check for risks each year.							Screen once between ages 18 and 79.		
Hepatitis B	Check for risks each year. Screen if at increased risk of infection.									
Sudden cardiac arrest/death	Check for risks each year.									

* Height and weight are used to find BMI. BMI is used to see if a person has the right weight for their height or is under or overweight for their height. BMI percentile is used in children ages 2 to 19 to identify where a child falls in relation to other children.

This guide is just for your information; it is not meant to take the place of medical care or advice. Some people may be at higher risk for health issues due to their family history, their race or ethnicity, or other reasons. Talk to your child's doctor if you have concerns about their health.

Please note: Coverage of these services varies by health plan.

Adult screening — women

Yearly wellness visits

During your annual visit, your doctor may perform or recommend certain screenings based on your age or medical history, including those on the chart below. Your doctor may also talk to you about:

- Diet and physical activity.
- Mental health, including depression.
- Oral and dental health.
- Tobacco use or how to quit.
- Avoiding secondhand smoke.
- Substance use, including the use of alcohol and prescription or illegal drugs.
- Skin cancer risks.
- Intimate partner violence.
- Minimizing exposure to UV radiation.
- Family planning, including:
  - Safe sex (counseling may be provided to prevent STIs in adults at increased risk).
  - Birth control to help avoid unplanned pregnancy.
  - Spacing out pregnancies to have the best birth outcomes.
  - Folic acid supplements for women of childbearing age.
- Importance of exercise in adults over age 65 in preventing falls.

Keep in mind, the following recommendations are categorized by "men" and "women," and are driven by biological sex (male and female) rather than gender identity. Meet with your doctor to determine which recommendations best apply to you based on individual factors, such as your sex assigned at birth and current anatomy.[1]

Screening	When to receive screening
Height, weight, and BMI[2]	Screen each year or as your doctor suggests. Women with a high BMI (30 or more) should be offered intensive weight loss interventions to help increase exercise and improve eating habits.
Blood pressure	Screen each year or as your doctor suggests. Recheck high readings at home.
Cardiovascular (CVD) risk assessment	Screen as your doctor suggests between ages 40 and 75. Women at increased risk should be offered a low- to moderate-dose statin (cholesterol medicine). Lipid screening may be required to assess risk.
Glucose screening for type 2 diabetes	Screen as your doctor suggests from ages 35 to 70, especially if overweight or obese. Individuals with high blood sugar should talk to their doctor about intensive counseling interventions to promote a healthy diet and physical activity.
Osteoporosis	The test to check how dense your bones are should start no later than age 65; women at menopause should talk to their doctor about osteoporosis and have the test when at risk.
Depression and suicide risk	Each year
Anxiety	Each year up to age 65
Breast cancer risk	Screen as your doctor suggests if 35 years or older and at increased risk. Women who are at increased risk for breast cancer and at low risk for adverse medication effects should be offered risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors.
Mammogram[3]	Each year from ages 40 to 65+. Consider screening every 2 years from ages 50 to 74.
BRCA gene risk assessment	Screen as doctor suggests in women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations.
Cervical dysplasia	Receive regular Pap tests beginning at age 21. Talk to your doctor about how often you should be screened and for how long.
Cervical cancer: 21 to 29	Receive a Pap test every three years.
Cervical cancer: 30 to 65	Receive a Pap test every three years or HPV testing alone or in combination with Pap test (co-testing) every five years.

Screening	When to receive screening
Cervical cancer: 65+	Stop screening at age 65 if last three Pap tests or last two co-tests (Pap plus HPV) within the previous 10 years were normal. If there is a history of an abnormal Pap test within the past 20 years, discuss continued screening with your doctor.
Colorectal cancer	At age 45 and continuing until 75, your doctor may suggest any one of these test options: • Direct visualization tests – Colonoscopy – CT colonography – Flexible sigmoidoscopy • Stool-based tests – Fecal immunochemical test (FIT) – Guaiac-based fecal occult blood test (gFOBT) – Multi-targeted stool DNA test (FIT-DNA)
Lung cancer (low-dose computed tomography (LDCT))	Screen beginning at age 50 for those with a 20-pack-per-year smoking history and currently smoke or have quit within the past 15 years.
Hepatitis B	Screen if at increased risk for infection.
Hepatitis C	Screen once between the ages of 18 and 79.
Gonorrhea and chlamydia	Sexually active women aged 24 and under. Women over age 25, if at increased risk of infection.
Syphilis	Screen if at increased risk of infection.
Human immunodeficiency virus (HIV)	Screen as your doctor suggests between ages 19 and 60. People at high risk of HIV acquisition should be offered pre-exposure prophylaxis (PrEP).
Tuberculosis	Screen for latent infection if at increased risk.

1 Caughey AB, Krist AH, Wolff TA, et al: USPSTF Approach to Addressing Sex and Gender When Making Recommendations for Clinical Preventive Services. JAMA. (November 16, 2021): pubmed.ncbi.nlm.nih.gov/34694343.

2 Height and weight are used to check body mass index (BMI). Checking someone's BMI helps determine if they are a healthy weight for their height, or if they are under or overweight.

3 Women should talk to their doctor and make a personal choice about the best age to start having mammograms and possibly screen every two years when older.

This guide is just for your information; it is not meant to take the place of medical care or advice. Some people may be at higher risk for health issues due to their family history, their race or ethnicity, or other reasons. Talk to your doctor if you have concerns about your health.

Please note: Coverage of these services varies by health plan.

Pregnancy

Within the first three months of pregnancy, it's important to visit a doctor to set up a prenatal care plan. At each prenatal visit, your doctor will check your and your baby's health. They may also talk to you about:

- What is safe to eat during pregnancy.
- How to safely exercise while pregnant.
- Avoiding tobacco, drugs, alcohol, and other substances.
- Breastfeeding and how to access lactation supplies and services after delivery if needed.

Testing for you

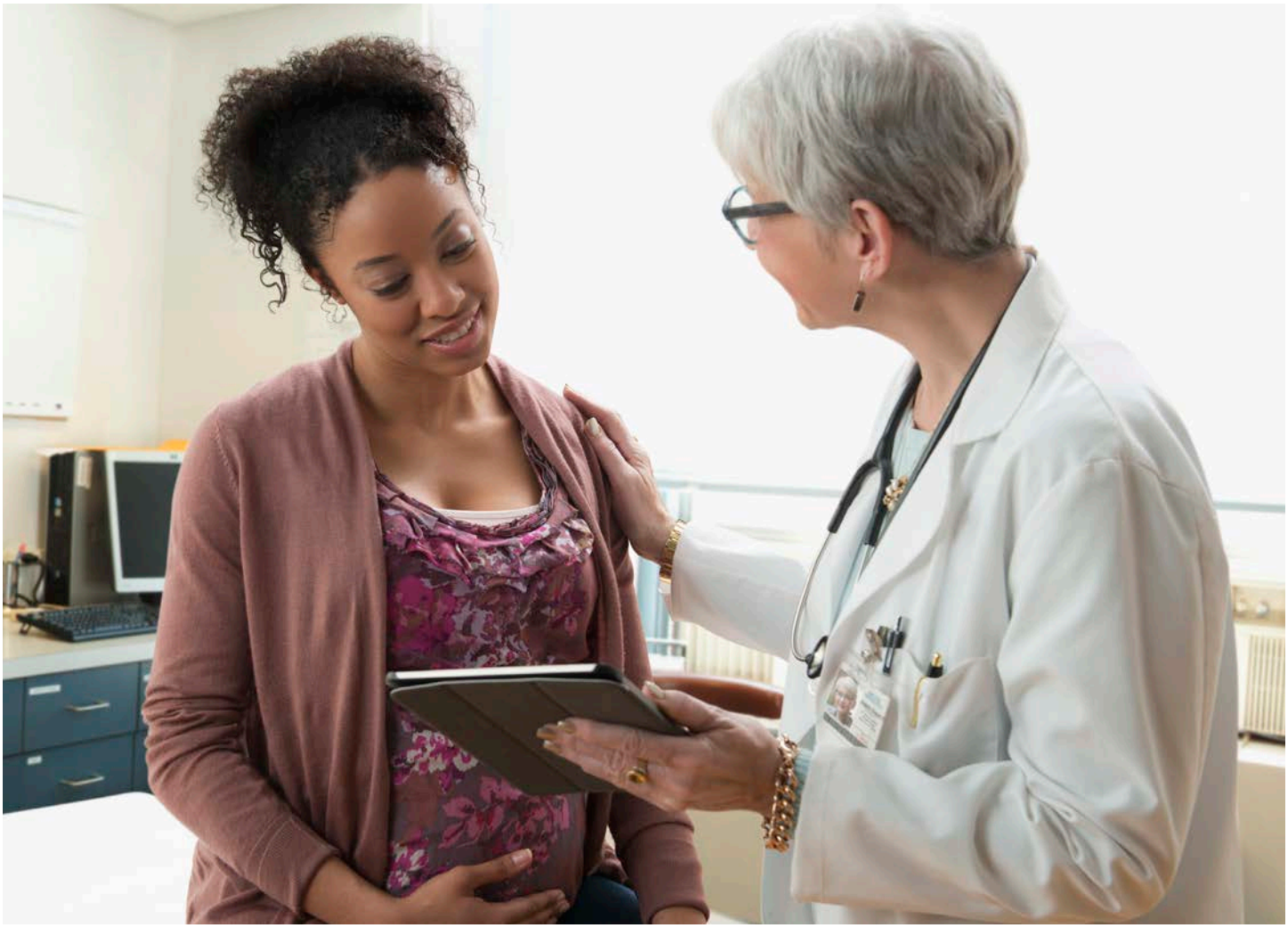
Your doctor may recommend the following tests and preventive screenings during pregnancy:

- Depression and suicide risk screenings (during and after pregnancy)
- Gestational diabetes screening at 24 weeks or later
- Preeclampsia* screening (to test for high blood pressure during pregnancy)
- Hematocrit/hemoglobin (blood count)
- Rubella immunity (to determine if you need the rubella vaccine after delivery)
- Rh(D) blood type and antibody testing (to see if your blood type and your baby's blood type are compatible). If you are Rh(D) negative, you may need to repeat this test between 24 and 28 weeks.
- Hepatitis B screening (recommended at first prenatal visit)
- HIV screening if your HIV status is unknown, including those who present in labor or at delivery. Individuals at high risk of HIV acquisition should be offered pre-exposure prophylaxis (PrEP).
- Syphilis
- Urine for asymptomatic bacteriuria

Testing for your baby

The following tests and others can check your baby for health concerns before they're born. Which tests you need and when you need them depend on your age as well as your medical and family history. Talk to your doctor about which tests you may need, what the results say about your baby, and the possible risks associated with each test.

- Amniocentesis (an ultrasound and testing of the fluid surrounding your baby)
- Cell-free DNA (a blood test to check for chromosomal abnormalities in the baby)
- Chorionic villus sampling (checks for birth defects)
- Ultrasound tests (to look at the baby in the womb). During the first three months, these are done along with blood tests to check the baby for chromosomal abnormality risk.



Vaccines

It's best to receive most vaccines before pregnancy. However, certain vaccines are recommended during pregnancy to boost your and your baby's immunity, including:

- **Flu**: If you are pregnant during flu season (October through March), your doctor may want you to get the inactivated flu shot.
- **Tdap**: Pregnant teens and adults need a Tdap vaccine during each pregnancy. It's best to receive the vaccine between weeks 27 and 36 of pregnancy, although it may be given at any time.
- **Respiratory syncytial virus (RSV)**: Depending on the season, your doctor may recommend one dose of this vaccine between 32 and 36 weeks.

You should not get the following vaccines while pregnant:

- **Measles, mumps, rubella (MMR)**
- **Varicella (chickenpox)**

* If you have a high risk of preeclampsia, your doctor may recommend taking a low-dose aspirin to prevent other problems while you are pregnant.

This guide is just for your information; it is not meant to take the place of medical care or advice. Some people may be at higher risk for health issues due to their family history, their race or ethnicity, or other reasons. Talk to your doctor if you have concerns about your health.

Please note: Coverage of these services varies by health plan.

Adult screening — men

Yearly wellness visits

During your annual visit, your doctor may perform or recommend certain screenings based on your age or medical history, including those on the chart below. Your doctor may also talk to you about:

- Diet and physical activity.
- Mental health, including depression.
- Oral and dental health.
- Tobacco use or how to quit.
- Avoiding secondhand smoke.
- Substance use, including the use of alcohol and prescription or illegal drugs.
- Skin cancer risks.
- Intimate partner violence.
- Family planning, including:
  - Safe sex (counseling may be provided to prevent STIs in adults at increased risk).
  - Preventing unplanned pregnancy with a partner.
- Minimizing exposure to UV radiation.
- Importance of exercise in adults over age 65 in preventing falls.

Keep in mind, the following recommendations are categorized by "men" and "women," and are driven by biological sex (male and female) rather than gender identity. Meet with your doctor to determine which recommendations best apply to you based on individual factors, such as your sex assigned at birth and current anatomy.[1]

Screening	When to receive screening
Height, weight, and BMI[2]	Screen each year or as your doctor suggests. Men with a high BMI (30 or more) should be offered intensive weight loss interventions to help increase exercise and improve eating habits.
Abdominal aortic aneurysm (enlarged blood vessels in the abdomen)	Screen once between ages 65 and 75 if you have ever smoked.
Blood pressure	Screen each year or as your doctor suggests. Recheck high readings at home.
Cardiovascular (CVD) risk assessment	Screen as your doctor suggests between ages 40 and 75. Men at increased risk should be offered a low- to moderate-dose statin (cholesterol medicine). Lipid screening may be required to assess risk.
Colorectal cancer	From ages 45 to 75, your doctor may suggest one or more of these test options: • Direct visualization tests – Colonoscopy – CT colonography – Flexible sigmoidoscopy • Stool-based tests – Fecal immunochemical test (FIT) – Guaiac-based fecal occult blood test (gFOBT) – Multi-targeted stool DNA test (FIT-DNA)

Caughey AB, Krist, AH, Wolff TA, Barry MJ, Henderson JT, Owens DK, et al: *USPSTF Approach to Addressing Sex and Gender When Making Recommendations for Clinical Preventive Services.* JAMA (November 16, 2021): pubmed.ncbi.nlm.nih.gov/34694343.

2. Height and weight are used to check body mass index (BMI). Checking someone's BMI helps determine if they are a healthy weight for their height, or if they are under or overweight.

Screening	When to receive screening
Glucose screening for type 2 diabetes	Screen as your doctor suggests from ages 35 to 70, especially if overweight or obese. Individuals with high blood sugar should talk to their doctor about intensive counseling interventions to promote a healthy diet and physical activity.
Hepatitis C	Screen once between the ages of 18 and 79.
Hepatitis B	Screen if at increased risk for infection.
HIV	Screen as your doctor suggests between ages 19 and 65. Older adults should be screened if at increased risk of infection. Men at high risk of HIV acquisition should be offered pre-exposure prophylaxis (PrEP).
Syphilis	Screen if at increased risk of infection.
Prostate cancer	From ages 55 to 69, talk with your doctor about the risks and benefits of prostate cancer tests.
Lung cancer (with low-dose computed tomography (LDCT))	Start screening at age 50 if you have a 20-pack-per-year smoking history and currently smoke or have quit within the past 15 years.
Tuberculosis	Screen for latent infection if at increased risk.
Depression and suicide risk	Each year
Anxiety	Each year up to age 65

This guide is just for your information; it is not meant to take the place of medical care or advice. Some people may be at higher risk for health issues due to their family history, their race or ethnicity, or other reasons. Talk to your doctor if you have concerns about your health.

Please note: Coverage of these services varies by health plan.

Suggested vaccine schedule

Vaccine	Birth	1 to 2 months	2 months	4 months	6 months	6 to 12 months	12 to 15 months
Respiratory syncytial Virus (RSV)				✓			
Hepatitis A							✓ 2-dose series ...
Hepatitis B	✓	✓		✓		✓	
Rotavirus			✓ 2- or 3-dose series				
Diphtheria, tetanus, pertussis (DTaP)			✓	✓	✓		
Tetanus, diphtheria, pertussis (Td/Tdap)							
Haemophilus influenza type b (Hib)			✓ 3 to 4 doses; first dose at 2 months, last dose at 12 to 15 months				
Influenza (flu)					✓ Suggested each year from 6 months to 65+ years of age; ...		
COVID-19					✓ Vaccination recommended for...		
Pneumococcal conjugate (PCV)			✓	✓	✓		✓
Pneumococcal polysaccharide (PCV15, PCV20, PPSV23)							
Measles, mumps, rubella (MMR)							✓
Inactivated polio virus (IPV)			✓	✓		✓	
Human papillomavirus (HPV)							
Meningococcal							
Varicella (chickenpox)							✓
Zoster							

Respiratory syncytial virus (RSV): Recommendations for infants depend on maternal RSV vaccination status, when they were born, and individual risk factors.

Hepatitis A (ages 2 to 18): A two-dose series given between 12 and 23 months, with 6 to 18 months between doses. If you or your child has never had this vaccine, talk to your doctor about catching up.

Hepatitis B: The first dose should be given within 24 hours of birth. Children may receive an extra dose (four-dose series) at 4 months if the combination vaccine is used after initial dose. Individuals over 60 should discuss potential vaccination with their doctor.

Rotavirus (RV): Consists of a two- or three-dose series (depending on the brand of vaccine used).

Tdap (children through adults): If you or your child (age 7 or older) never received this vaccine, talk to your doctor about a catch-up vaccine.

Haemophilus influenza type b (Hib): Depending on the brand of vaccine, children should receive a three- or four-dose series.

Influenza (flu): Visit **cdc.gov/flu** to learn more about this vaccine. Children 6 months to 8 years getting the vaccine for the first time should receive two doses four weeks apart.

COVID-19: For information on the current COVID-19 vaccination schedule and dosage details, visit **cdc.gov/covidschedule**.

For additional information about vaccines, visit **cdc.gov/vaccines**.

15 to 18 months	19 to 23 months	4 to 6 years	11 to 12 years	13 to 18 years	19 to 59 years	60 to 64 years	65+ years
✓							
✓ … between 12 and 23 months							
					✓		
✓		✓					
			✓		✓ Every 10 years		
✓ … two doses at least four weeks apart are recommended for children between 6 months and 8 years who are receiving the vaccine for the first time							
✓ … those 6 months to 65 years. Speak to your doctor about frequency and dosage.							
							✓
		✓			✓ 1 to 2 doses depending on risk factors		
		✓					
			✓ 2- or 3-dose series				
			✓ MenACWY: Ages 11 to 12, booster at 16 MenB: Ages 16 to 23				✓
		✓			✓ 2-dose series		✓
					✓ 2-dose series for ages 50+; 2 to 6 months apart		

Pneumococcal (PCV15, PCV20, PPSV23): Adults age 65 and older who have never received PCV, or whose history is unknown, should follow the recommended schedule. If you previously had a PSV13 vaccination, ask your doctor what dose is best for you.

Measles, mumps, rubella (MMR): Teens and adults should be up to date on their MMR vaccines. Number of doses will depend on individual risk factors.

Inactivated polio virus (IPV): Children should receive four doses of this vaccine between 2 months and 6 years old.

Human papillomavirus (HPV): Children who are 11 to 12 years old receive two doses at least six months apart. (The series can start at age 9.) Those who start the series later (ages 15 to 26) need three doses to protect against cancer-causing HPV infection.

Adults aged 27 to 45 should talk to their doctor to see if an HPV vaccine is right for them.

Meningococcal: For healthy teens who are not high risk, two doses of MenA,C,W,Y should be given. Vaccination is also recommended for children and adults at increased risk. Timing is based on the brand of vaccine, the age the first dose was given, and individual risk factors. Those aged 16 to 23 who are not high risk should discuss the MenB vaccine with their doctor.

Varicella (chickenpox): For children who have not had chickenpox. Two doses may also be recommended for adults born after 1980. They should talk to their doctor for a recommendation.

Zoster: Two doses of the Shingrix (HZ/su) vaccine, given 2 to 6 months apart, is recommended for adults aged 50 and older, including those who previously received the Zostavax (shingles) vaccine.

Learn more about your plan and what services it covers by downloading the Sydney℠ Health mobile app or visiting anthem.com.

For additional information on various health and wellness topics, visit our blog at anthem.com/blog/.


Anthem
And Its Affiliate HealthKeepers, Inc.

Anthem
And Its Affiliate HealthKeepers, Inc.

Receive virtual care and support

through our Sydney Health mobile app

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

Visit with a doctor for common medical concerns

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

Receive care for your behavioral health

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

What people say about virtual care visits[2]

92% were able to book a virtual visit sooner than an in-person visit

89% said the doctor they saw was professional and helpful

92% thought the doctor understood their concerns

How to download our Sydney Health app:

Scan the QR code with your phone's camera.

Download on the App Store

GET IT ON Google Play

sydney℠

Use Sydney Health app to:

Help you manage your blood pressure

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

Connect with a dermatologist

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

Help you avoid diabetes

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

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

Download our Sydney Health app.

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

Visit anthem.com.

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

1 Appointments subject to availability.
2 Based on Sydney Health utilization trends from top national clients.
3 The doctor will determine what medications should be prescribed or refilled.
4 Online counseling is not appropriate for all kinds of problems. If you are in crisis or having suicidal thoughts, it's important that you seek help immediately. Please text, chat, or call 988 (Suicide and Crisis Lifeline), or 911 for help. If your issue is an emergency, call 911 or go to your nearest emergency room. Emergency services are not provided through virtual care on the Sydney Health app or anthem.com.
5 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed through virtual care on the Sydney Health app or anthem.com.
6 Anthem internal data, 2020.

Anthem

Connect with us 24/7

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

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

Sydney Health

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

How to use Sydney Health's interactive chat

Download the app

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

Use the Sydney Health interactive chat feature to:

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

Discover how Sydney Health simplifies health care

Download and start using the app today.

Download on the App Store | ANDROID APP ON Google play

Use your smartphone camera to scan this QR code.

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Live Chat

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

How to use Live Chat

Log in using Sydney Health or anthem.com:

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

Choose your chat topic:

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

- 24/7 NurseLine
- Behavioral health
- Benefits, coverage, and claims
- Maternity and baby benefits
- Pharmacy

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

Anthem Skill for Alexa

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

How to use Anthem Skill

Enable the Skill:

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

Use the Skill to:

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

Wellbeing Solutions

Supporting your whole health matters

We want to support your whole health the best way possible. That's why your health plan includes Wellbeing Solutions, a suite of programs to help you with everyday health and your overall well-being.

Use the **Sydney℠ Health** mobile app and **anthem.com** anytime to access Wellbeing Solutions programs and resources that meet your healthcare needs.

Making your well-being a priority

Explore Wellbeing Solutions programs on the Sydney Health app

Proactive support

MyHealth Check-in. By taking a short health assessment, you will receive personalized health tips and resources to support your needs. We will offer details on programs that can help you lower health risks, reach your personal goals, and prevent future health problems.

MyHealth Advantage. We provide you with a confidential health summary that includes reminders for checkups, tests, and exams; lists of claims and prescriptions; and general health tips.

24/7 NurseLine. Talk to a trained, registered nurse without leaving your home. Convenient, 24/7 care means you can quickly get the answers to common health concerns.

Mental health resources

Behavioral Health Advantage (BHA). If you're trying to manage a behavioral health condition or cope with substance use disorder, you don't have to face it alone. Our behavioral health case managers are licensed mental health professionals. They offer caring support for you and your family, including 24/7 drug and alcohol assistance, to improve your quality of life. Tap into our knowledge hub, featuring tools, articles, and webinars on topics like suicide awareness and support, autism, attention deficit hyperactivity disorder (ADHD), and post-traumatic stress disorder (PTSD). We're here to help guide you on the path to better mental health and well-being.

Emotional Wellbeing Resources. Learn effective ways to develop resilience, reduce stress, and practice mindfulness through online programs and personalized coaching. Digital tools help you identify thoughts and behavior patterns that affect your emotional well-being.

Autism Spectrum Disorder Program. Receive support for a covered family member with an autism spectrum disorder. Our licensed behavior analysts can help you navigate the healthcare system and address any unique family challenges. We focus on the whole family and work with all of you to help you understand services and access care.

Anthem

Condition-based support

Concierge Care. This program pairs you with a personal health advocate to provide coaching and digital resources on health conditions, such as type 2 diabetes and heart failure, as well as when you are being discharged from an inpatient setting.

Case Management. After an illness or hospital stay, you can receive one-on-one support and care coordination from our team of medical professionals. They partner with you and your family to help guide you through the healthcare system and make the most of your benefits. Their goal is to understand your needs from all angles and help you get the best care possible.

Building Healthy Families. Whether you're planning for a family, are pregnant, or are postpartum, you can access digital tools and educational resources to support the needs of your growing family.

ConditionCare. Receive one-on-one, digital support from a healthcare professional for a chronic condition, like asthma or diabetes, to help you reach your health goals.

Cancer Care. If you or a family member is facing a cancer diagnosis or have started treatment, the Cancer Care Navigator program can provide one-on-one guidance and digital support when it matters most.

Connect with Sydney Health

Sydney Health offers useful health and wellness tips and personalized action plans that can help you reach your unique well-being goals. Use Sydney Health for a convenient way to find care and details about your health plan coverage along with Wellbeing Solutions benefits.

Download, open, register, and/or sign into the Sydney Health mobile app.

1. Go to homepage > Scroll down > Choose Personalize Your Care (for web and mobile).
2. Browse the wellness programs included in your plan.

Scan this QR code with your smartphone to download the Sydney Health app.

We care about you

With Wellbeing Solutions, you can work toward your health goals, knowing you are supported and cared for at every step. If you have any questions, call Member Services or visit **anthem.com**.

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Anthem

Building Healthy Families

A new program to support growing families

Benefits to help you thrive

- Family Care Coaches
- Interactive health trackers
- 24/7 access
- Personalized content

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

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

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Designed with you in mind

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

Tools to help you stay organized

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

Health and wellness expertise for you and your family

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

Personalized pregnancy support

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

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

Enroll today

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

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

ConditionCare

Need a little ...

or a lot of support for your health condition?

Let ConditionCare be your wellness guide

Managing an ongoing health condition isn't easy. And having a little extra help and encouragement can make all the difference. That's why we offer ConditionCare, a **no-cost health and wellness program** that provides tools, resources, and support to members and their covered dependents with:*

- Asthma (pediatric or adult)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Diabetes, types 1 and 2 (pediatric or adult)
- Heart failure (HF)

If you or a loved one under your insurance plan has any of the conditions named above, you can participate at no extra cost.

Signing up for ConditionCare is easy

We'll call you or you can call us toll free at 866-960-0812. When we talk, we'll verify your identity, ask you a few questions about your health and invite you to join the program.

Once enrolled in ConditionCare, you get:

Educational resources, like email newsletters.

Support from nurse care managers, dietitians, and other health care professionals to help you reach your health goals. .

Depending on your health, you may be asked to complete a health questionnaire. Your answers will help us figure out how to best support you.

Then, we'll put you in touch with a nurse care manager, who'll provide guidance on reaching your health goals. He or she will also follow up periodically to offer encouragement and advice.

To really take advantage of the program, we encourage you to register on **anthem.com** and opt in for email communication.

Anthem®

And Its Affiliate HealthKeepers, Inc.

ConditionCare doesn't replace your doctor. Instead, our nurse care managers work with your doctor to help you follow your care plan.

You and your covered family members can stay in ConditionCare as long as you keep your health plan and the program is offered. Taking part doesn't affect your monthly payments.

Please note: The health information you share with ConditionCare nurse care managers, your doctor, and other health professionals is kept confidential and used only to develop your care plan. Plus, every time we call, we'll ask you to confirm your name and date of birth before talking about your health.

We're here to help

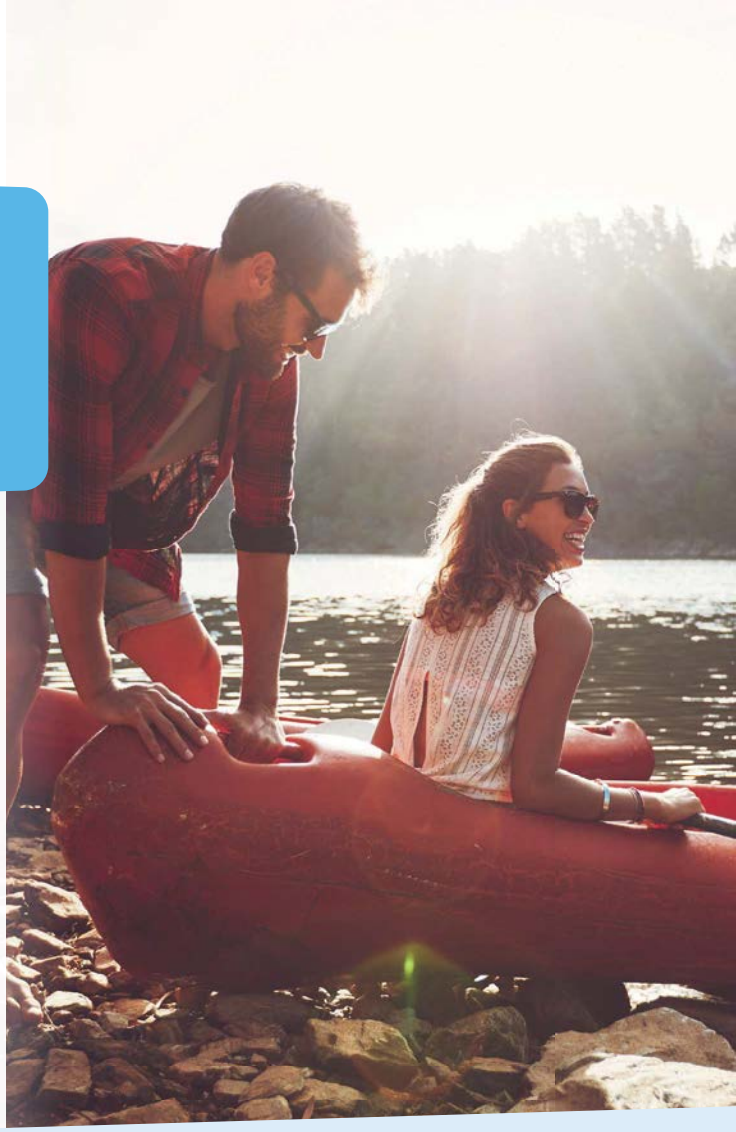
Call ConditionCare at
866-960-0812 today!

Anthem
And Its Affiliate HealthKeepers, Inc.

MVAFQ1305A Rev. 10/20

ConditionCare: health support

We are here to support your health



If you have an ongoing condition that might put you at risk for future health issues, we want to help. When you join ConditionCare, a no-cost health and wellness program, we work with you to help you better manage your physical and mental health.

ConditionCare can help you or your covered family members manage conditions such as:

- High cholesterol, high blood pressure, high blood sugar, and weight problems
- Coronary artery disease (CAD) and heart failure
- Diabetes
- Asthma and chronic obstructive pulmonary disease (COPD)
- Low back pain, arthritis, hip and knee replacement, and osteoporosis

Based on your needs when you sign up for ConditionCare, the program provides:

- Telephone access to healthcare professionals who can answer questions and work with you to optimize your health.
- Continued guidance from care managers, nurses, pharmacists, dietitians, and other healthcare professionals who work together to help you reach your health goals.
- Educational guides and tips to help you learn more about your condition.

To find out more about the ConditionCare program, call us toll free at **866-962-0963.**

The ConditionCare nurses are very knowledgeable and very willing to listen and offer good advice. They follow up when they say they are going to. I really appreciate that. Awesome program.

– ConditionCare participant

Extra support at no extra cost

Your health is a priority. Call us today at **866-962-0963** to learn how the ConditionCare program can help you take care of your health. Sign-up is quick and easy.

Anthem

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Save money

with SpecialOffers and discounts

As part of your health plan, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through SpecialOffers, which can help you save money while taking care of your health.

Dental, hearing, and vision

Dental

RefreshaDent

Save on premium dentures sent direct to your home. You can receive a 50% discount on a lifetime warranty. This program includes a lifetime digital record of your dentures for easy replacement.

Hearing

NationsHearing®

Receive hearing screenings and in-home service at no additional cost. You can also receive hearing aids at a discounted rate.

Hearing Care Solutions

Receive no-cost hearing exams and discounts on hearing aids. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, batteries for two years, and unlimited visits for one year.

Amplifon

Save on top-quality care and ongoing service and support for your hearing aids.

Eyewear

Glasses.com® and 1-800 CONTACTS®

Shop for the latest brand-name frames at a fraction of the cost for similar frames from other retailers. You can also receive additional savings on orders of $100 or more, plus no-cost shipping and returns.

EyeMed

Take advantage of discounts on new glasses, nonprescription sunglasses, and eyewear accessories.

LASIK

Premier LASIK Network

Save on LASIK when you choose any featured Premier LASIK Network provider.

TruVision

Save on LASIK eye surgery at over 1,000 locations.

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Health and fitness

Health

BREVENA

Enjoy a discount on BREVENA skin care creams and balms for smooth, rejuvenated skin from head to toe.

ChooseHealthy®

Discounts are available on acupuncture, chiropractic, massage, podiatry, physical therapy, and nutritional services. You also have discounts on fitness equipment, wearable health trackers, and health products such as vitamins and nutrition bars.

LifeMart®

Receive deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services, yoga classes, sports gear, and vision care.

Fitness

Active&Fit Direct™

Choose from more than 11,900 participating fitness centers nationwide at a discounted rate. This program is offered through American Specialty Health Fitness, Inc.

Fitbit®

Work toward your fitness goals with Fitbit trackers and smartwatches that fit your lifestyle and budget.

Garmin®

Discounts are available on select Garmin wellness devices.

Husk Wellness

Discounts are available for gym memberships, fitness equipment and technology, and fitness and nutrition coaching.

Family and home

Family

23andMe®

Save on health and ancestry kits to learn about your wellness, ancestry, and more.

WINFertility®

Save up to 40% on infertility treatment. WINFertility helps make quality treatment more affordable.

Home

Nationwide® pet insurance

Receive discounts when you enroll through your company or organization. Additional savings are available when you enroll multiple pets.

ASPCA® Pet Health Insurance

Find reduced rates on pet insurance and choose from three levels of care, including flexible deductibles and custom reimbursements.

Medicine and treatment

Medicine

Puritan's Pride®

Choose from a large selection of discounted vitamins, minerals, and supplements.

Allergy Control Products and National Allergy Supply™

Save on select doctor-recommended products such as allergy-friendly bedding, air purifiers and filters, and asthma products. Some orders qualify for no-cost ground shipping within the contiguous U.S.

Treatment

The Living Well Course Series

Choose one of the online wellness programs and save on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address alcohol or substance dependence.

Learn more about SpecialOffers
Log in to anthem.com, choose **Care**, and select **Discounts.**

Expanding your virtual care options

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

Visit with a doctor at your convenience

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

1 Chat with a doctor 24/7 without an appointment

- Urgent care support for health issues, such as allergies, a cold, or the flu.
- New prescriptions[1] for concerns such as a cough or a sinus infection.

2 Schedule a virtual primary care appointment

- Routine care, including virtual annual preventive care (wellness) visit and prescription refills.[1,2,3,4]
- Personalized care plans for chronic conditions, such as asthma or diabetes.

Assess your symptoms with the Symptom Checker

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

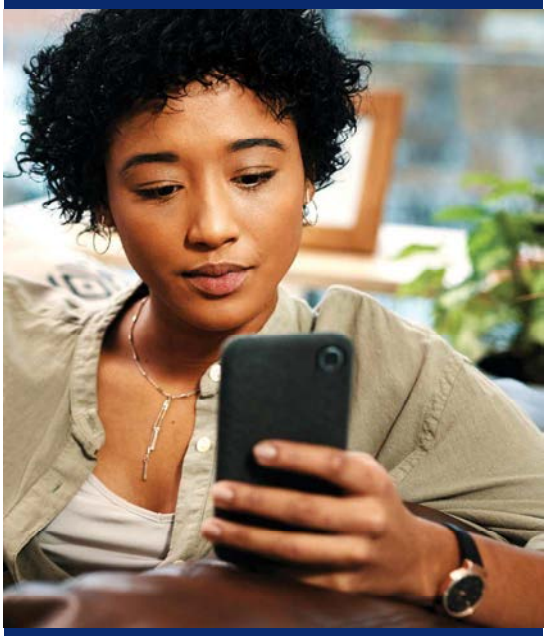
Save money and time with virtual care

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

▷ Download our Sydney Health mobile app today.

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

GET IT ON Google Play | Download on the App Store



85% of virtual visits **resolve** the person's need.[5]

1 Virtual annual preventive care (wellness) visits through the Sydney Health app are available starting September 2022. The virtual annual preventive care (wellness) visit is covered in full unless the employer has a limit or cap under their benefit plan.
2 Virtual primary care medical services provided by Preventive Medical Associates P.C. through an arrangement with Hydrogen Health, which provides the virtual care platform.
3 Eligible employees are those who have not yet had an annual preventive care (wellness) visit during the plan year (either virtual or in-person) whose group benefit plan covers a virtual primary care exam. If an employer group has a cap on the number of preventive care (wellness) visits that are covered in full and the employee has exceeded the cap but would like to have another preventive care (wellness) visit, they may be responsible for copays and other out-of-pocket costs for the visit. Employees should consult their benefit plan and/or contact Member Services if they have any questions.
4 Your doctor will determine if a prescription is needed at time of visit.
5 K Health analysis of Q4 2020 visit depositions.

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

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

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

The ins and outs of coverage

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

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

The ins and outs of coverage

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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

The ins and outs of coverage

Determining the primary and secondary plans

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

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

The ins and outs of coverage

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered

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

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

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

- **Administrative Charges**

  — Charges to complete claim forms,

  — Charges to get medical records or reports,

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

- **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.

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

  — Acupuncture,

  — Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,

  — Holistic medicine,

  — Homeopathic medicine,

  — Hypnosis,

  — Aroma therapy,

  — Massage and massage therapy,

  — Reiki therapy,

  — Herbal, vitamin or dietary products or therapies,

  — Naturopathy,

  — Thermography,

  — Orthomolecular therapy,

  — Contact reflex analysis,

  — Bioenergetic synchronization technique (BEST),

  — Iridology-study of the iris,

  — Auditory integration therapy (AIT),

  — Colonic irrigation,

  — Magnetic innervation therapy,

What's Not Covered

— Electromagnetic therapy,

— Neurofeedback / Biofeedback.

- **Autopsies** Autopsies and post-mortem testing.
- **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
- **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- **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.
- **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at **anthem.com**.

  If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
- **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

  This Exclusion does not apply to:

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

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

  — Surgery or procedures on newborn children to correct congenital abnormalities.
- **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

What's Not Covered

- **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
- **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **Dental Devices for Snoring** Oral appliances for snoring.
- **Dental Treatment** Dental treatment, except as listed below.

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

  — Removing, restoring, or replacing teeth;

  — Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);

  — Services to help dental clinical outcomes.

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

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

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

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

What's Not Covered

- **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.
- **Eye Exercises** Orthoptics and vision therapy.
- **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

  — Cleaning and soaking the feet.

  — Applying skin creams to care for skin tone.

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

  This Exclusion does not apply to the treatment of corns, calluses, and care of toenails when the services are medically necessary.
- **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

  If your Group is not required to have Workers' Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- **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.
- **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- **Hearing Aids** For Members age 19 or older, hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids and over-the-counter hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- **Hearing Aids** Over-the-counter hearing aids.
- **Home Health Care**

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

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

What's Not Covered

- **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.
- **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Infertility Treatment** Testing or treatment related to infertility.
- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.
- **Medical Equipment, Devices, and Supplies**
  - — Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - — Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - — Non-Medically Necessary enhancements to standard equipment and devices.
  - — Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
  - — Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
- **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to **www.medicare.gov** for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
- **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- **Non-approved Drugs** Drugs not approved by the FDA.
- **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that must be covered by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- **Off label use** Off label use, unless we approve it.
- **Personal Care, Convenience and Mobile/Wearable Devices**

What's Not Covered

- — Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
- — First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
- — Home workout or therapy equipment, including treadmills and home gyms,
- — Pools, whirlpools, spas, or hydrotherapy equipment,
- — Hypoallergenic pillows, mattresses, or waterbeds,
- — Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- — Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

- **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.
- **Private Hospital Room** A private hospital room.
- **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
  - — Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - — Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - — Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.
- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that HealthKeepers determines require in-person contact and/or equipment that cannot be provided remotely.
- **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- **Specialty Drugs** Specialty Drugs for which another source of payment is available, including but not limited to, manufacturer and copay assistance programs. This Exclusion applies to the full amount charged for any such Drug, not just the amount of alternate assistance potentially available, and applies regardless of whether such alternate assistance is received or pursued*
- **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

What's Not Covered

- **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services** Vision services not described as Covered Services in this Booklet.
- **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

  This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

- **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by the Plan or the PBM.
- **Car-T Cellular Therapy** Car-T cellular therapy as well as any Drugs, procedures, health care services related to it that use T-cells, genetically altered in a lab, to destroy disease-causing cells, including cancer.
- **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
- **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at **anthem.com**.
- **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.

What's Not Covered

- **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.
- **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
- **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by HealthKeepers.
- **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What’s Covered" section.

  This Exclusion does not apply to over-the-counter drugs that must be covered under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **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 "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” benefit. Please see that section for details.
- **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.
- **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment (DME), Medical Devices and Supplies” benefit. Please see that section for details.
- **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

What's Not Covered

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

  The exception to this Exclusion is described in "Covered Prescription Drugs" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.
- **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
- **Specialty Drugs** Specialty Drugs for which another source of payment is available, including but not limited to, manufacturer and copay assistance programs. This Exclusion applies to the full amount charged for any such Drug, not just the amount of alternate assistance potentially available, and applies regardless of whether such alternate assistance is received or pursued .
- **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- **Weight Loss Drugs** Any Drug mainly used for weight loss.>

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Protecting your privacy

How we keep your information safe and secure

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

You also have certain rights and responsibilities when receiving your healthcare. To understand how we protect your privacy, rights, and responsibilities when receiving healthcare, and your rights under the Women's Health and Cancer Rights Act, go to **anthem.com/privacy**. 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 your eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

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

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 iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾiਸਲ ਕਰਨ ਦਾ ਅਿਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਰਿਵਸ 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.

Anthem

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

Carelon Health, Inc. is a separate company providing care management services on behalf of Anthem BCBS.

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.

Virtual text and video visits powered by K Health. LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

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