Choosing and using your plan

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

PPO Plan 4, PPO Plan 6 HSA and HMO Plan 11 POS Open Access

Virginia Private Colleges Benefits Consortium: Virginia Union University

Effective January 1, 2024
Time to choose your plan

Your trusted health partner

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

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

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

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

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Understanding your benefits

When choosing your plan, think of the four “C”s:

1. **Consider** your personal situation. If things have changed since last year, you may want to look for benefits that fit those needs.

   - Have your healthcare needs changed?
   - Do you go to the doctor more often now?
   - Is a special prescription drug needed?
   - Are you expecting a baby?

2. **Compare** all the costs:

   - Monthly payment
   - Deductible
   - Coinsurance
   - Copay
   - Out-of-pocket limit

3. **Check** to see if your doctors, hospitals, and other healthcare professionals are covered by the plan.

4. **Choose** the right plan for your needs.

Common healthcare terms

<table>
<thead>
<tr>
<th><strong>Coinsurance:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Once you’ve met your deductible, you and your health plan share the cost of covered healthcare services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you will pay.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Copay:</strong></th>
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<tbody>
<tr>
<td>A flat fee you pay for covered services, such as doctor visits.</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Deductible:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A set amount you pay each year for covered services before your plan starts to pay for covered healthcare costs. You can use your HSA/FSA/HRA toward your deductible.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Out-of-pocket limit:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>This is the maximum amount you could pay before your plan starts to pay 100% of all covered healthcare costs. It’s the sum of the deductible and coinsurance amounts.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Premium:</strong></th>
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</thead>
<tbody>
<tr>
<td>The premium, also called a monthly payment, is what you pay for the plan. It’s the money that comes out of your paycheck.</td>
</tr>
</tbody>
</table>

Glossary of terms:
Visit anthem.com/glossary

What you pay and what your plan pays

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

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

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

**PPO**

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

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

**HMO**

The health maintenance organization (HMO) plan covers services from doctors and hospitals in your plan’s network. It is the least flexible plan but has a lower monthly payment.

- You must choose a primary care doctor from the plan for preventive care such as checkups and screenings.
- If you need care from a specialist, such as an orthopedic doctor or a cardiologist, you don’t need to visit your PCP first to get a referral. This can save you time and a copay.
Explore your plan options

Health savings account (HSA)

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

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

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

What your plan will cover

Your medication coverage

Your plan covers:

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

Your drug list

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

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

To find the latest drug lists:

- Visit anthem.com and enter National Direct Plus VA 4 Tier in the search bar.

Your pharmacy options

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

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

How your pharmacy benefits work

Depending on the plan you choose, you will either have a copay or coinsurance.

- Copay: A fixed amount you pay for a covered prescription until you reach your out-of-pocket maximum. Your copay is based on which tier the drug is on. See the Save money with Tier 1 drugs section for details.

- Coinsurance: Your share of the drug costs. It is the percentage of costs you pay for a covered prescription until you reach your out-of-pocket maximum.

Once you’re a member, you can use the Price a Medication tool on anthem.com to compare costs and find generic equivalents.
How to use your plan

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

Register for online tools and resources

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

Sydney Health mobile app

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

Working with you:

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

Working for you:

- Chat - If you have questions about your benefits or need information, Sydney Health can help you quickly find what you’re looking for and connect you to an Anthem Health Guide.
- Virtual Care - Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.
- Community Resources - This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

Use your ID card from your phone

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

Find a doctor in your plan

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

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

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

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

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

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care to avoid costly emergency room visits and long wait times.
- Have a virtual chat with your doctor from your mobile device or computer.
Make the most of your pharmacy benefits

Understanding medicine coverage and costs

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

Coverage requirements

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

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

You have pharmacy options

Choose a pharmacy that’s in your plan. You have many retail pharmacies from which to choose. Use a pharmacy that is in your plan to avoid paying full price. To find a pharmacy in your plan, visit anthem.com/pharmacyinformation/rxnetworks.html, and choose your network list.

The Advantage Network features about 58,000 pharmacies nationwide where you can fill prescriptions and pay your typical cost share amount. You have access to well-known retail pharmacies such as CVS, Target, Kroger, Costco, and Walmart. Most independent pharmacies are also included in the Advantage Network. To find a pharmacy, visit anthem.com/pharmacyinformation/rxnetworks.html and choose the Advantage Network list.
Make the most of your pharmacy benefits

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

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

For more information, go to anthem.com/FAQs, select your state, and then Pharmacy.

<table>
<thead>
<tr>
<th>Drug type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 Preferred generic drugs</td>
<td>$</td>
</tr>
<tr>
<td>Tier 2 Preferred brand-name and newer, higher-cost generic drugs</td>
<td>$$</td>
</tr>
<tr>
<td>Tier 3 Nonpreferred brand-name and generic drugs</td>
<td>$$$</td>
</tr>
<tr>
<td>Tier 4 Preferred specialty drugs (brand name and generic)</td>
<td>$$$$</td>
</tr>
</tbody>
</table>
Summary of Benefits of Coverage
(SBC’s)

Effective January 1-December 31, 2024
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso). For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call (833) 597-2358 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>What is the overall <strong>deductible</strong>?</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$750/person or $1,500/family for In-Network Providers. $750/person or $1,500/family for Non-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
<td></td>
</tr>
</tbody>
</table>

| Are there services covered before you meet your **deductible**? | Yes. Preventive Care for In-Network Providers, Vision for In-Network and Non-Network Providers. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at [https://www.healthcare.gov/coverage/preventive-care-benefits/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |

| Are there other **deductibles** for specific services? | Yes. $150/person or $300/family for Prescription Drugs In-Network Providers. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |

| What is the **out-of-pocket limit** for this plan? | $3,250/person or $6,500/family for In-Network Providers. $4,500/person or $9,000/family for Non-Network Providers. This plan has a separate Out of Pocket Maximum of $3,350/person or $6,700/family for Prescription Drugs In-Network Providers. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |

| What is not included in the **out-of-pocket limit**? | Premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |

| Will you pay less if you use a **network**? | Yes, KeyCare. See [www.anthem.com](https://www.anthem.com) or call (833) | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive |
For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.

**Do you need a **referral** to see a **specialist?**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least): $20/visit</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Non-Network Provider (You will pay the most): 30% coinsurance</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$20 PCP/$40 Spec/visit Or 20% coinsurance in a facility setting</td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>Costs may vary by site of service.</td>
</tr>
</tbody>
</table>

**If you need drugs to treat your illness or condition**


| Tier 1 - Typically Generic | $10/prescription, Prescription Drug deductible does not apply (retail and home delivery) | Not covered (retail) and Not covered (home delivery) |
| Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | Greater of $40 or 30% coinsurance up to $80/prescription, Prescription Drug deductible applies (retail) and Greater of $80 or 30% coinsurance up to $160/prescription, Prescription Drug deductible applies (home delivery) | Not covered (retail) and Not covered (home delivery) |
| Tier 3 - Typically Non-Preferred Brand and Generic drugs | Greater of $60 or 40% coinsurance up to | Not covered (retail) and Not covered (home delivery) |

For more information, refer to “National Direct Plus Drug List” at http://www.anthem.com/pharmacyinformation/.

*See Prescription Drug section on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Non-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$120/prescription, Prescription Drug deductible applies (retail) and Greater of $120 or 40% coinsurance up to $240/prescription, Prescription Drug deductible applies (home delivery)</td>
<td>Not covered (retail) and Not covered (home delivery)</td>
</tr>
<tr>
<td>Tier 4 - Typically Preferred Specialty (brand and generic)</td>
<td>50% coinsurance up to $200/prescription, Prescription Drug deductible applies (retail) and Not covered (home delivery)</td>
<td>30% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 PCP/$40 Spec./visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit $20/visit</td>
<td>Office Visit 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>Other Outpatient 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$20 PCP/$40 Spec. pregnancy for the first 1 visit deductible does not apply.</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or</td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>90 visits/benefit period.</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>have other special health needs</td>
<td>Rehabilitation services</td>
<td>ST $20 PCP/$40 Spec/visit PT and OT $30/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>ST $20 PCP/$40 Spec/visit PT and OT $30/visit</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>100 days/stay for skilled nursing services. Preauthorization.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>*See Durable Medical Equipment Section</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Excluded Services &amp; Other Covered Services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>$15/visit deductible does not apply</td>
<td>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>• Acupuncture</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>• Dental care (Pediatric)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Routine foot care unless medically necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dental Check-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Infertility treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

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

<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
<td>Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></td>
</tr>
<tr>
<td>Private-duty nursing 16 hours/member/benefit period Facility Setting only</td>
<td>Chiropractic care 30 visits/benefit period</td>
</tr>
<tr>
<td>Routine eye care (Adult) 1 exam/benefit period</td>
<td>Hearing Aids</td>
</tr>
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<td>$750</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Other copayment</td>
<td>$40</td>
<td>$40</td>
</tr>
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This EXAMPLE event includes services like:

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

This EXAMPLE event includes services like:

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

This EXAMPLE event includes services like:

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>$5,600</th>
<th>$2,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$750</td>
<td>$900</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,100</td>
<td>$1,100</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$3,310</td>
<td>$2,220</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Joe would pay:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$900</td>
<td>$200</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
<td>$1,100</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>The total Joe would pay is</td>
<td>$2,220</td>
<td></td>
<td>$2,220</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Mia would pay:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$750</td>
<td>$900</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
<td>$200</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
<td>$200</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What isn’t covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td>$1,250</td>
<td>$1,250</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

*This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

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

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,600/person or $3,200/family for In-Network Providers. $1,600/person or $3,200/family for Non-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive Care. For more information see below.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$3,000/person or $6,000/family for In-Network Providers. $4,000/person or $8,000/family for Non-Network Providers.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. KeyCare. See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 597-2358 for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td>20% coinsurance (You will pay the least)</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td></td>
<td>20% coinsurance (You will pay the least)</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td></td>
<td>No charge (You will pay the least)</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td></td>
<td>20% coinsurance (You will pay the least)</td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance (You will pay the most)</td>
<td></td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Typically Generic (Tier 1)</td>
<td>20% coinsurance (retail and home delivery)</td>
<td>For more information, refer to “National Direct Plus Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a></td>
</tr>
<tr>
<td>Typical Preferred Brand &amp; Non-Preferred Generic Drugs (Tier 2)</td>
<td>20% coinsurance (retail and home delivery)</td>
<td>Not covered (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td>Typically Non-Preferred Brand and Generic drugs (Tier 3)</td>
<td>20% coinsurance (retail and home delivery)</td>
<td>Not covered (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td>Typically Preferred Specialty (brand and generic) (Tier 4)</td>
<td>20% coinsurance (retail) and Not covered (home delivery)</td>
<td>Not covered (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance (You will pay the least)</td>
<td>---none---</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>30% coinsurance (You will pay the most)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>20% coinsurance (You will pay the least)</td>
<td>---none---</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% coinsurance (You will pay the least)</td>
<td>Covered as In-Network</td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>20% coinsurance (You will pay the least)</td>
<td>Covered as In-Network</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance (You will pay the least)</td>
<td>---none---</td>
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<td>Physician/surgeon fees</td>
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| **If you need mental health, behavioral health, or substance abuse services**        | Outpatient services                  | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most)             | Office Visit  
Virtual visits (Telehealth) benefits available.  
Other Outpatient ---------none--------- |
|                                                                                    |                                      | Office Visit 20% coinsurance  
Other Outpatient 20% coinsurance | Office Visit 30% coinsurance  
Other Outpatient 30% coinsurance |                                                        |
|                                                                                    | Inpatient services                   |                                      |                                                        |                                                        |
|                                                                                    |                                      | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most)             |                                                        |
|                                                                                    |                                      | Office Visit 20% coinsurance  
Other Outpatient 20% coinsurance | Office Visit 30% coinsurance  
Other Outpatient 30% coinsurance |                                                        |
| **If you are pregnant**                                                            |                                      | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most)             | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                                    |                                      | Office visits 20% coinsurance  
Childbirth/delivery professional services 20% coinsurance | Office visits 30% coinsurance  
Childbirth/delivery facility services 30% coinsurance |                                                        |
| **If you need help recovering or have other special health needs**                  |                                      | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most)             | 90 visits/benefit period for Home Health and Private Duty Nursing combined.  
Costs may vary by site of service.  
*See Therapy Services section.  
100 days/stay for skilled nursing services combined.  
Preauthorization |
|                                                                                    |                                      | Home health care 20% coinsurance | 30% coinsurance |                                                        |
|                                                                                    |                                      | Rehabilitation services 20% coinsurance | 30% coinsurance |                                                        |
|                                                                                    |                                      | Habilitation services 20% coinsurance | 30% coinsurance |                                                        |
|                                                                                    |                                      | Skilled nursing care 20% coinsurance | 30% coinsurance |                                                        |
|                                                                                    |                                      | Durable medical equipment 20% coinsurance | 30% coinsurance | *See Durable Medical Equipment Section |
|                                                                                    |                                      | Hospice services 20% coinsurance | 30% coinsurance | --none-- |
| **If your child needs dental or eye care**                                         | Children’s eye exam                  | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most)             | *See Vision Services section |
|                                                                                    | $15/visit, deductible does not apply | Reimbursed Up to $30 |                                                        |                                                        |
|                                                                                    | Children’s glasses                   | Not covered | Not covered |                                                        |
|                                                                                    | Children’s dental check-up           | Not covered | Not covered | --none-- |

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| * Acupuncture  
*Bariatric surgery  
*Dental care (Adult)  
*Long-term care  |
| *Cosmetic surgery  
*Infertility treatment  
*Weight loss programs  
*Children’s dental check-up  
*Glasses for a child  
*Routine foot care unless medically necessary |

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

- Chiropractic care 30 visits/benefit period
- Private-duty nursing 90 visits/benefit period combined with Home Health
- Hearing aids
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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</tr>
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<td>$1,600</td>
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</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,600</td>
<td>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,400</td>
<td>$20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th>What isn’t covered</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

The total Peg would pay is **$3,060**

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

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,600</td>
<td>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,400</td>
<td>$800</td>
</tr>
</tbody>
</table>

<table>
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</tbody>
</table>

The total Joe would pay is **$2,420**

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

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,600</td>
<td>$1,600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,400</td>
<td>$800</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th>What isn’t covered</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>Limits or exclusions</td>
</tr>
</tbody>
</table>

The total Mia would pay is **$1,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.
### Virginia Private Colleges: Plan 11 HMO-POS Open Access

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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500/person or $1,000/family for In-Network Providers, $1,000/person or $2,000/family for Non-Network Providers.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Primary Care Specialist Visit Preventive Care for In-Network Providers, Vision for In-Network and Non-Network Providers.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $150/person or $300/family for Prescription Drugs In-Network Providers. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,000/person or $6,000/family for In-Network Providers, $3,500/person or $7,000/family for Non-Network Providers. This plan has a separate Out of Pocket Maximum of $3,600/person or $7,200/family for Prescription Drugs In-Network Providers.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if</td>
<td>Yes, HealthKeepers. See</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s...</td>
</tr>
</tbody>
</table>
you use a **network provider**?  www.anthem.com or call (833) 597-2358 for a list of **network providers**.

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

Do you need a **referral** to see a **specialist**?  No.  You can see the **specialist** you choose without a **referral**.

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network Provider (You will pay the least) $25/visit <strong>deductible</strong> does not apply</td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Non-Network Provider (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>Virtual visits (Telehealth) benefits available.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge 30% <strong>coinsurance</strong></td>
<td>You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>In-Network Provider (You will pay the least) $25 PCP/$50 Spec/visit <strong>deductible</strong> does not apply</td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Non-Network Provider (You will pay the most) 30% <strong>coinsurance</strong></td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>In-Network Provider (You will pay the least) $10/prescription, Prescription Drug <strong>deductible</strong> applies (retail and home delivery) Not covered (retail) and Not covered (home delivery)</td>
<td>For more information, refer to “National Direct Plus Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a></td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>Greater of $40 or 30% <strong>coinsurance</strong> up to $80/prescription, Prescription Drug <strong>deductible</strong> applies (retail) and Greater of $80 or 30% <strong>coinsurance</strong> up to $160/prescription, Prescription Drug <strong>deductible</strong> applies (home delivery) Not covered (retail) and Not covered (home delivery)</td>
<td>Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>Greater of $60 or 40% <strong>coinsurance</strong> up to $120/prescription, Not covered (retail) and Not covered (home delivery)</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need / Limitations, Exceptions, &amp; Other Important Information</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Prescription Drug <strong>deductible</strong> applies (retail) and Greater of $120 or 40% <strong>coinsurance</strong> up to $240/prescription, Prescription Drug <strong>deductible</strong> applies (home delivery)</td>
<td>Not covered (retail) and Not covered (home delivery)</td>
</tr>
<tr>
<td>Tier 4 - Typically Preferred Specialty (brand and generic)</td>
<td>50% <strong>coinsurance</strong> up to $200/prescription, Prescription Drug <strong>deductible</strong> applies (retail) and Not covered (home delivery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after facility fee is paid</td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% <strong>coinsurance</strong></td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$100/trip <strong>deductible</strong> does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 PCP/$50 Spec/visit <strong>deductible</strong> does not apply</td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after facility fee is paid</td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit <strong>deductible</strong> does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$25 PCP/ $50 Spec/pregnancy for the first 1 visit <strong>deductible</strong> does not apply</td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$200/pregnancy <strong>deductible</strong> does not apply</td>
<td>30% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Non-Network Provider (You will pay the most)</td>
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<td></td>
<td></td>
<td>(You will pay the least)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90 visits/benefit period for Home Health and Private Duty Nursing combined.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>30% coinsurance</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>There is a 30-visit limit for physical and occupational therapy, combined. 30-visit limit for speech therapy. Early Intervention Services Pre-determination of eligibility required</td>
<td></td>
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<td></td>
<td></td>
<td>100 days/stay for skilled nursing services. Preauthorization.</td>
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<td>*See Durable Medical Equipment Section</td>
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<td>---none---------</td>
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</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$15/visit deductible does not apply</td>
<td>Reimbursed Up to $30</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic care 30 visits/benefit period
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 90 visits/benefit period combined with Home Health
- Hearing Aids
- Bariatric surgery

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

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

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

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

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

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

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

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
### About these Coverage Examples:

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

---

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

- The plan’s overall deductible $500
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other copayment $50

This EXAMPLE event includes services like:

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

**Total Example Cost** $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,300</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $60

**The total Peg would pay is** $2,460

---

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

- The plan’s overall deductible $500
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other copayment $50

This EXAMPLE event includes services like:

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

**Total Example Cost** $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$150</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $20

**The total Joe would pay is** $1,870

---

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

- The plan’s overall deductible $500
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other copayment $50

This EXAMPLE event includes services like:

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

**Total Example Cost** $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$30</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions $0

**The total Mia would pay is** $1,030

---

The plan would be responsible for the other costs of these EXAMPLE covered services.
Welcome to your Blue View Vision plan!

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

### Your Blue View Vision Plan Benefits

<table>
<thead>
<tr>
<th>Routine Eye Exam</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>A comprehensive eye examination</td>
<td>$15 copay</td>
<td>Up to $30 allowance</td>
<td>Once every calendar year</td>
</tr>
</tbody>
</table>

### Using Your Blue View Vision Plan

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

### Additional Savings on Eyewear and More

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

### Out-of-Network

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

**To Fax:** 866-293-7373  
**To Email:** onclaims@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 the number on the back of your ID card.

This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member’s policy, which shall control in the event of a conflict with this overview.
**OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retinal Imaging</strong></td>
<td>At member’s option can be performed at time of eye exam</td>
<td>Not more than $39</td>
</tr>
<tr>
<td><strong>Eyeglass Frame</strong></td>
<td>When purchased as part of a complete pair of eyeglasses*</td>
<td>35% off retail price</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td>When purchased as part of a complete pair of eyeglasses*:</td>
<td></td>
</tr>
<tr>
<td>Standard plastic material</td>
<td>- Single Vision</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td>- Bifocal</td>
<td>$70</td>
</tr>
<tr>
<td></td>
<td>- Trifocal</td>
<td>$105</td>
</tr>
<tr>
<td><strong>Eyeglass Lens Options and Upgrades</strong></td>
<td>When purchasing a complete pair of eyeglasses’ (frame and lenses), you may choose to upgrade your new eye glass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- UV Coating</td>
<td>$15</td>
</tr>
<tr>
<td></td>
<td>- Tint (Solid and Gradient)</td>
<td>$15</td>
</tr>
<tr>
<td></td>
<td>- Standard Scratch-Resistant Coating</td>
<td>$15</td>
</tr>
<tr>
<td></td>
<td>- Standard Polycarbonate</td>
<td>$40</td>
</tr>
<tr>
<td></td>
<td>- Standard Anti-Reflective Coating</td>
<td>$45</td>
</tr>
<tr>
<td></td>
<td>- Standard Progressive Lenses (add-on to Bifocal)</td>
<td>$55</td>
</tr>
<tr>
<td></td>
<td>- Other Add-Ons</td>
<td>20% off retail price</td>
</tr>
<tr>
<td><strong>Conventional Contact Lenses</strong></td>
<td>Discount applies to materials only</td>
<td>15% off retail price</td>
</tr>
<tr>
<td>(non-disposable type)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

![Glasses.com](glasses.com) | [contactsdirect.com](contactsdirect.com) | [1800contacts.com](1800contacts.com) | [lenscrafters.com](lenscrafters.com) | [targetoptical.com](targetoptical.com) | [Ray-Ban](ray-ban.com/insurance)

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

Other savings offers are available on eyewear, hearing aids and even LASIK laser vision correction surgery through a variety of vendors. Just log in at anthem.com, select discounts, then Vision, Hearing & Dental.
Stay on top of your health
Use your preventive care benefits

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

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

Preventive care vs. diagnostic care

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

Adult preventive care

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

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)2, 3
- Depression screening
- Diabetes screening (type 2)4
- Eye chart test for vision5
- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Hepatitis C virus (HCV) screening
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for those ages 50 to 80 who have a history of smoking 20 packs or more per year and still smoke, or who have quit within the past 15 years3
- Obesity: related screening and counseling5
- Prostate cancer screenings, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

Women’s preventive care:6

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met7
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling8, 9
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening8
- Interpersonal and domestic violence: screening and counseling
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV, and depression9
- Well-woman visits
- Monkeypox and/or smallpox (at risk)
- Pneumococcal (pneumonia)
- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19)
- Varicella (chickenpox)
- Zoster (shingles)

Immunizations:

- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)
- Monkeypox and/or smallpox (at risk)
- Pneumococcal (pneumonia)
- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19)
- Varicella (chickenpox)
- Zoster (shingles)

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

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the group policy provisions will rule. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for exclusions and limitations.
Child preventive care

Preventive physical exams, screenings, and tests:

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

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19)
- Whooping cough

Coverage for pharmacy items

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

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

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

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease (CVD), preeclampsia, and colorectal cancer in adults younger than age 70
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for individuals ages 45 to 75
- Generic low-to-moderate dose statins for individuals ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Metformin (850 mg) to prevent or delay progression of diabetes in individuals ages 35 to 70
- Preexposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for individuals ages 18 and older

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

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria
- Contraceptives, including generic prescription drugs, brand name drugs with no generic equivalent, and OTC items like condoms and spermicides
- Folic acid for women ages 55 or younger who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

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

Save time and effort filling your regular prescriptions

Set up home delivery through CarelonRx Mail for the prescriptions you take long-term for conditions like high blood pressure, diabetes, heart disease, or asthma. You’ll receive your medications at your door and enjoy the convenience of not having to visit the pharmacy.

With home delivery, you can count on:

- **Convenience.** Medications are delivered directly to your home or any location you choose.
  - Manage your prescriptions with the Sydney℠ Health app or at anthem.com.
  - Expect first-time home delivery orders to take about two weeks and refills to take 3 to 5 days.
  - Set up reminders and automatic refills, too.

- **Safety.** All orders are checked by a licensed pharmacist before they ship. Discreet packaging is:
  - Tamperproof
  - Weatherproof
  - Temperature controlled, if needed

- **Peace of mind.** You’re less likely to miss a dose and more likely to stay on track with the treatment your doctor prescribed when you switch to home delivery.* Trained pharmacists can also answer your questions and help you 24/7.

- **Hassle-free service.** CarelonRx Mail will contact your doctor to order a new, 90-day prescription if you need one. If a medication preapproval is needed, the home delivery team will reach out to you for consent before shipping your medication.

- **Savings.** Many medications cost less when you fill a 90-day supply instead of three 30-day supplies. Shipping is always free.

**Start home delivery now with these steps**

1. Visit the Pharmacy page on anthem.com, choose the Pharmacy tab on the Sydney Health app, or scan the QR code with your phone’s camera. Register your member account if you haven’t already.

2. Choose Request a New Prescription.

3. Type in the prescription you’d like delivered.

4. Under the name and cost of your prescription, select Request a New Prescription.

5. Fill in any blank fields, such as shipping address, payment method, and prescriber.

6. First-time requestors will need to select Continue to Medical Profile.

7. Verify any allergies or health conditions, then select Continue to Submit Order.

**We’re here to help**

Call CarelonRx Mail at 833-320-1180 or use the live chat feature on Sydney Health or anthem.com.

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Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022 CarelonRx is an independent company providing pharmacy benefit management services on behalf of your health plan.
Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc., serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123, are independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
The Sydney Health mobile app makes healthcare easier
Access personalized health and wellness information wherever you are

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

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

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

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

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

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

¿Prefieres obtener información en español?
Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, seleccione el menú dentro de la aplicación Sydney Health y elige el idioma de la aplicación. También puedes visitar espanol.anthem.com.

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

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

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile applications on behalf of your health plan. ©2023 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health. Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Massachusetts (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nebraska: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare); HMO plans underwritten by WellPoint Health Networks, Inc. (WHN). Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they turned 26.
1. At the employer level, which affects you and other employees covered by an employer’s plan, your plan can be:

<table>
<thead>
<tr>
<th>Renewed</th>
<th>Canceled</th>
<th>Changed</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your employer:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Keeps its status as an employer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Stays in our service area.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Meets our guidelines for employee participation and premium contribution.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Pays the required health care premiums.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Doesn’t commit fraud or misrepresent itself.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Your employer:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Makes a bad payment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Voluntarily cancels coverage (30-days advance written notice required).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>We decide to no longer offer the specific plan chosen by your employer (you’ll get a 90-day advance notice).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>◦ We decide to no longer offer any coverage in Virginia (you’ll get a 180-day advance notice).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Renewed</th>
<th>Canceled</th>
<th>When you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>◦ Stay eligible for your employer’s coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Pay your share of the monthly payment (premium) for coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Don’t commit fraud or misrepresent yourself.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Lose your eligibility for coverage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Don’t make required payments or make bad payments.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Commit fraud.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Are guilty of gross misbehavior.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Don’t cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Let others use your ID card.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ Use another member’s ID card.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>◦ File false claims with us.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Your coverage will be canceled after you receive a written notice from us.</td>
</tr>
</tbody>
</table>
**Special enrollment periods**

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

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

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

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

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

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

**When you’re covered by more than one plan**

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

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

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

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

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

- Any person to or for whom the overpayments were made
- Any health care company
- Any other organization
What’s Not Covered

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

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

1) Acts of War, Disasters, or Nuclear Accidents In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

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

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

4) Alternative / Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a) Acupuncture, (Removed when Acupuncture Rider is included)
   b) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   c) Holistic medicine,
   d) Homeopathic medicine,
   e) Hypnosis,
   f) Aroma therapy,
   g) Massage and massage therapy,
   h) Reiki therapy,
   i) Herbal, vitamin or dietary products or therapies,
   j) Naturopathy,
   k) Thermography,
   l) Orthomolecular therapy,
   m) Contact reflex analysis,
   n) Bioenergial synchronization technique (BEST),
   o) Iridology-study of the iris,
   p) Auditory integration therapy (AIT),
   q) Colonic irrigation,
   r) Magnetic innervation therapy,
   s) Electromagnetic therapy,
t) Neurofeedback / Biofeedback.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This Exclusion does not apply to:

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

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

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

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

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

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

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

   Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:
   - Removing, restoring, or replacing teeth;
   - Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
   - Services to help dental clinical outcomes.

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

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

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

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

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

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

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

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

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

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

   The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.
Please see the “Clinical Trials” section of “What’s Covered” for details about coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. Please also read the “Experimental or Investigational” definition in the “Definitions” section at the end of this Booklet for the criteria used in deciding whether a service is Experimental or Investigational.

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

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

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

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

36) **Foot Care** Routine foot care unless Medically Necessary. POS plans do not cover services for palliative or cosmetic food care including: flat foot, support devices, foot orthotics, subluxations of the foot, corns, calluses or care of toenails (except for those with diabetes or vascular disease), bunions (except capsular or bone surgery), fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. PPO plans cover weak, unstable or flat feet, bunions when an opening cutting operation is performed, non-routine treatment of corns or calluses, at least part of the nail root is removed, any medical necessary surgical procedures required for a food condition.

37) **Foot Orthotics** POS plans exclude support devices, arch support, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet, and foot orthotics. PPO plans will cover orthotics, including orthopedic shoes when an integral part of a leg brace, or when a doctor recommends the use of orthotics instead of surgery.

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

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

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

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

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

42) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
43) **Home Health Care**
   a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
   b) Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under “Hospice Care” in the “What’s Covered” section.

44) **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.

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

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

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

48) **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.

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

50) **Medical Equipment, Devices, and Supplies**
   a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
   b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
   c) Non-Medically Necessary enhancements to standard equipment and devices.
   d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
   e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.
   f) Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.

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

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

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

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

55) **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.

56) **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.

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

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

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

60) **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.

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

62) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
   a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
   b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
   c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

65) **Services Received Outside of Virginia** Services received from a Provider outside of Virginia. This does not apply to:
a) Emergency or Urgent Care; or
b) Covered Services approved in advance by Anthem. (Applicable to EPO products only)

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

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

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

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

70) **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).

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

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

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

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

75) **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.

76) **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.

77) **Weight Loss Services and Surgery** Except for Covered Services for the treatment of morbid obesity described in the Bariatric Surgery Rider, your coverage does not include benefits for services and supplies related to obesity or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem.

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

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

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

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

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

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

6. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law. (Added when contraceptives are excluded via a qualified religious exemption)

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

8. **Delivery Charges** Charges for delivery of Prescription Drugs.

9. **Drugs Given at the Provider’s Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy
in the office as described in the “Prescription Drugs Administered by a Medical Provider” section, or 
Drugs covered under the “Medical and Surgical Supplies” benefit – they are Covered Services.

10. Drugs Not on the Anthem Prescription Drug List (a formulary) You can get a copy of the list by 
calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a 
certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the “Prescription 
Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an 
exception.

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

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

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

14. Drugs That Do Not Need a Prescription Drugs that do not need a prescription by federal law 
(including Drugs that need a prescription by state law, but not by federal law), except for injectable 
insulin or other Drugs provided in the Preventive Care paragraph of the "What’s Covered" section. 
This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when 
recommended by the U.S. Preventive Services Task Force and prescribed by a physician.

15. Emergency Contraceptives Emergency contraceptives (also referred to as “the morning-after pill”), 
such as Plan B and Ella. (Added when contraceptive devices are excluded via partial religious 
exemption)

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

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

18. Gene Therapy Gene therapy that introduces or is related to the introduction of genetic material into a 
person intended to replace or correct faulty or missing genetic material. While not covered under the 
“Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, benefits may 
be available under the “Gene Therapy Services” benefit. Please see that section for details.

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

20. Hyperhidrosis Treatment Prescription Drugs related to the medical and surgical treatment of 
excessive sweating (hyperhidrosis).

21. Infertility Drugs Drugs used in assisted reproductive technology procedures to achieve conception 
(e.g., IVF, ZIFT, GIFT). (Removed when Infertility Rider is included)

22. Items Covered as Durable Medical Equipment (DME) Therapeutic DME, devices and supplies 
except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription 
Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the 
“Durable Medical Equipment (DME), Medical Devices and Supplies” benefit. Please see that section 
for details.

23. Items Covered Under the “Allergy Services” Benefit Allergy desensitization products or allergy 
serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail 
Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please 
see that section for details.
24. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

25. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.

26. **Non-approved Drugs** Drugs not approved by the FDA.

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

28. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

29. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

   The exception to this Exclusion is described in “Covered Prescription Drugs” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.

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

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

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

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

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

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

**Pending Regulatory Approval**

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Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
What’s Not Covered

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

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

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

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

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

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

4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a) Acupuncture, (Removed when Acupuncture Rider is included)
   b) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   c) Holistic medicine,
   d) Homeopathic medicine,
   e) Hypnosis,
   f) Aroma therapy,
   g) Massage and massage therapy,
   h) Reiki therapy,
   i) Herbal, vitamin or dietary products or therapies,
   j) Naturopathy,
   k) Thermography,
   l) Orthomolecular therapy,
   m) Contact reflex analysis,
   n) Bioenergial synchronization technique (BEST),
   o) Iridology-study of the iris,
   p) Auditory integration therapy (AIT),
   q) Colonic irrigation,
   r) Magnetic innervation therapy,
   s) Electromagnetic therapy,
t) Neurofeedback / Biofeedback.

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

6) **Autopsies** Autopsies and post-mortem testing.

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

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

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

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

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

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

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

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

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

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

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

This Exclusion does not apply to:

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

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

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

17) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
18) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

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

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

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

22) **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.

23) **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.

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

25) **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.

26) **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.

27) **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.

28) **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.

29) **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.

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

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

   Please see the “Clinical Trials” section of “What’s Covered” for details about coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. Please also read the “Experimental or Investigational” definition in the “Definitions” section at the end of this Booklet for the criteria used in deciding whether a service is Experimental or Investigational.
31) **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.

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

33) **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.

34) **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.

35) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
   a) Cleaning and soaking the feet.
   b) Applying skin creams to care for skin tone.
   c) Other services that are given when there is not an illness, injury or symptom involving the foot.

   This Exclusion does not apply to the treatment of corns, calluses, and care of toenails for patients with diabetes or vascular disease.

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

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

38) **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.

39) **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.

40) **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.

41) **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.

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

43) **Home Health Care**
   a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
   b) Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under “Hospice Care” in the “What’s Covered” section.
44) **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.

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

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

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

48) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur.

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

50) **Medical Equipment, Devices, and Supplies**
   a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
   b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
   c) Non-Medically Necessary enhancements to standard equipment and devices.
   d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
   e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.
   f) Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.

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

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

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

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

55) **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.

56) **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.

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

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

59) **Personal Care, Convenience and Mobile/Wearable Devices**
a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

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

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

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

e) Hypoallergenic pillows, mattresses, or waterbeds,

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

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

60) **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.

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

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

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

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

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

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

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

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

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

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

68) **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).

69) **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
70) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

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

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

73) **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.

74) **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.

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

76) **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.
What’s Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.

2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

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

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

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

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

6. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law. (Added when contraceptives are excluded via a qualified religious exemption)

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

8. **Delivery Charges** Charges for delivery of Prescription Drugs.

9. **Drugs Given at the Provider’s Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the “Prescription Drugs Administered by a Medical Provider” section, or Drugs covered under the “Medical and Surgical Supplies” benefit – they are Covered Services.

10. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at [www.anthem.com](http://www.anthem.com). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.

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

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

13. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by HealthKeepers.
14. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

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

15. **Emergency Contraceptives** Emergency contraceptives (also referred to as “the morning-after pill”), such as Plan B and Ella. (Added when contraceptive devices are excluded via partial religious exemption)

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

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

18. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene TherapyServices" benefit. Please see that section for details.

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

20. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

21. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT). (Removed when Infertility Rider is included)

22. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment (DME), Medical Devices and Supplies” benefit. Please see that section for details.

23. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.

24. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

25. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.

26. **Non-approved Drugs** Drugs not approved by the FDA.

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

28. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

29. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
The exception to this Exclusion is described in “Covered Prescription Drugs” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.

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

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

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

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

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

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

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**Pending Regulatory Approval**

HealthKeepers, Inc., an independent licensee of the Blue Cross and Blue Shield Association, serves all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
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 vui 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 vui. Bị khımı thố? Quý vui cũng có thể hỏi xin dịch đang khác của tài liệu này.”

**Arabic**

لقد الحق في الحصول على مساعدة يلتقى مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقته 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。

**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

**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.

**French**


**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**

Ընդունում են ինչ է դարձած եք բարելավել իման ճանաչեցության մասին տվյալները, որը նախատեսված է ցենել եմ ID պատկերը ունե՞ք:

**Farsi**

"شما این حق را دارید تا به صورت رایگان به زبان صادقی تن در دیدن دریافت "Member Services) کنید. کافی است با شماره خدمات اعضای شرکت شده روی کارت شناسایی خود تماس بگیرید." دلار اختلال بینایی هستید؟ می توانید این سند را به شما ارائه دهند که در خواست دهید.

**French**


**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 vui 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 vui. Bị khımı thố? Quý vui cũng có thể hỏi xin dịch đang khác của tài liệu này.”

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**French**

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

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

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

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

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

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

- If you have a new dependent. You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.

- If your eligibility for Medicaid or SCHIP changes. You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children’s Health Insurance Program (SCHIP) benefits because you’re no longer eligible.
  - You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

It’s important we treat you fairly
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.

For full details, read your plan document, which has all the details about your plan. You can find it on anthem.com.
Choosing and using your plan
Your guide to open enrollment and making the most of your benefits

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

If you have questions, please contact:
Grievances and Appeals /Claims address: P.O. Box 27401, Richmond, VA 23279

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

Reach an Anthem Health Guide by calling 833-597-2358. You also can go to anthem.com to send a secure email or chat with them online.