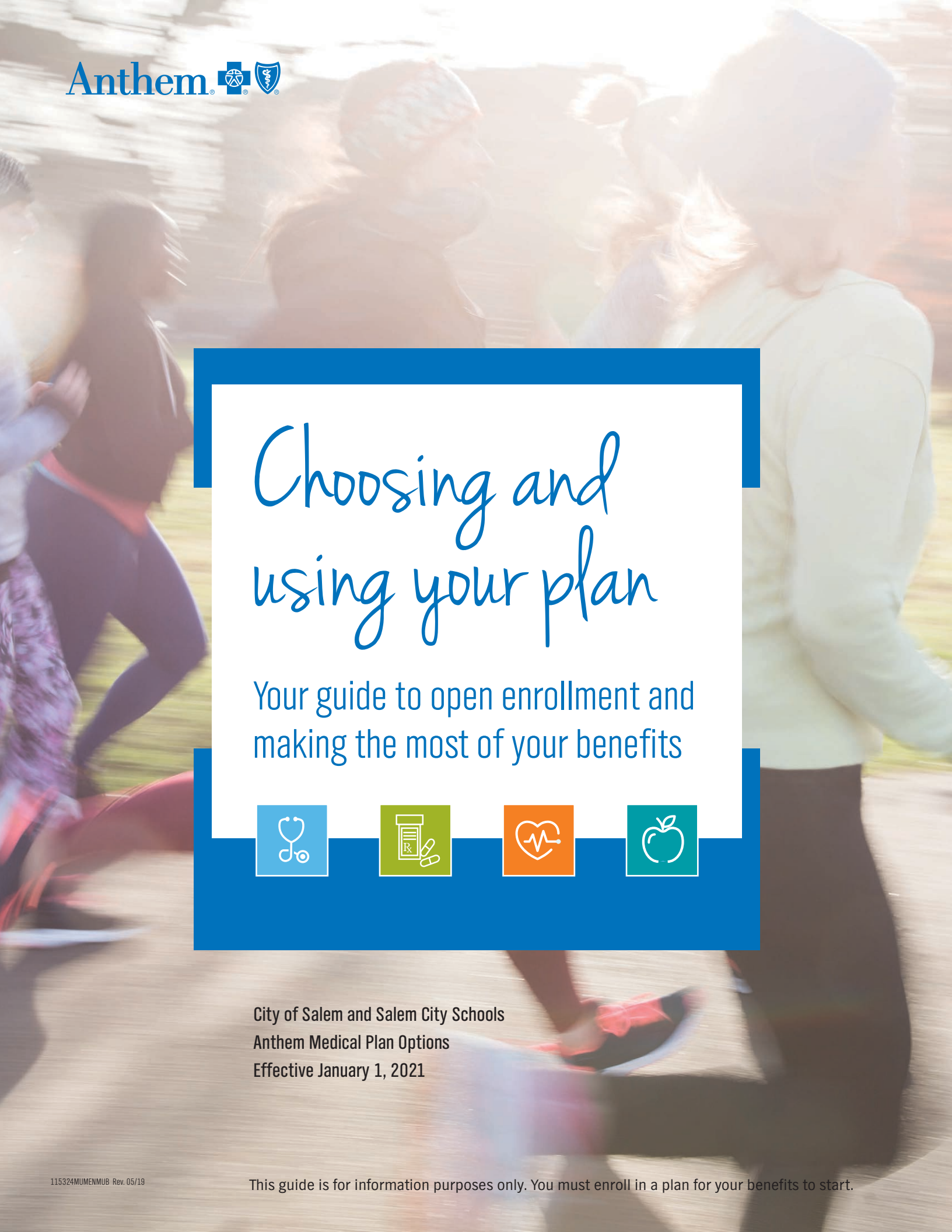


Choosing and using your plan

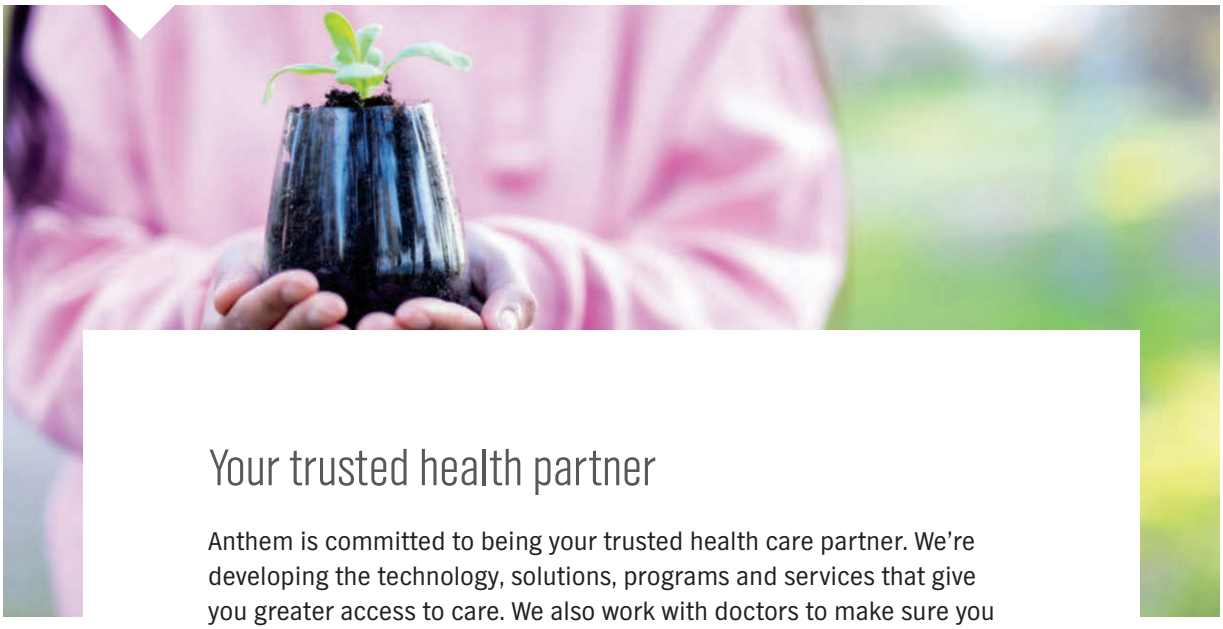
Your guide to open enrollment and making the most of your benefits

City of Salem and Salem City Schools
Anthem Medical Plan Options
Effective January 1, 2021

115324MUMENMUB Rev. 05/19

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

It’s time to choose your plan



Your trusted health partner

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

Save this guide

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

It's time to choose your plan

Let's get started

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

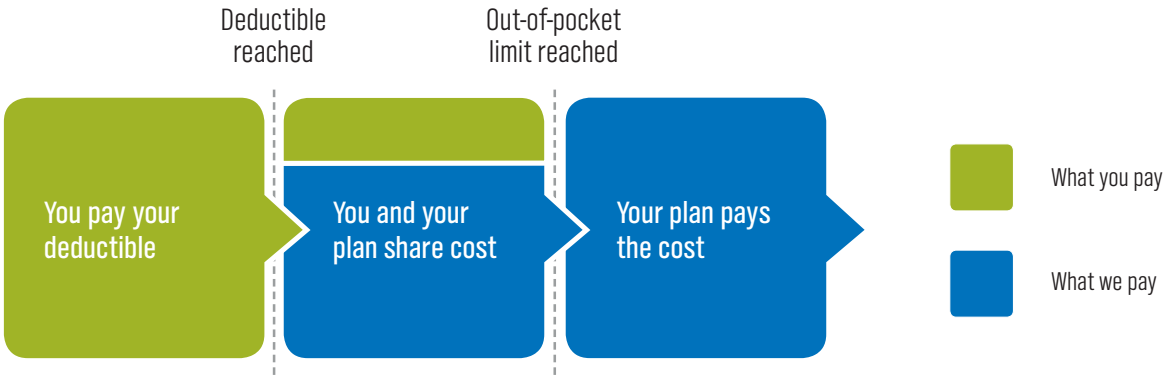
This guide will help you understand our plans. It's also full of tips, tools and resources that can help you reach your health and wellness goals when you become a member. So keep it handy to make the most of your benefits throughout the year.

Table of contents

The basics explained

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

What you pay and what your plan pays



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

Words that are helpful to know

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

Deductible:

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

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

Copay:

A flat fee you pay for covered services like doctor visits.

Coinsurance:

Once you've met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you'll pay.

Out-of-pocket limit:

This is the most you have to pay out of your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. And some plans may still have you pay a copay at the time of service.

Premium:

The premium, also called a monthly payment, is what you pay for the plan. It's the money that comes out of your paycheck. Think of it like a membership fee that's separate from what you pay when you get care.

Explore your plan options

Here's the part where you get to look at the plans and find the one that fits. What works best for you and your family?

PPO

With a Preferred Provider Organization (PPO), you can go to almost any doctor or hospital and you're covered — giving you more choices and flexibility. You get special rates for doctors in your plan, which lowers your out-of-pocket costs.

- You can choose a primary care provider (PCP) from the plan for preventive care, like checkups and screenings.
- You don't need to have a PCP to see a specialist.
- When you want to see a specialist, like 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.
- You'll pay less if you use doctors who are part of the PPO.
- You can see providers who aren't part of the PPO, but you'll pay more.
- Once you pay your deductible, you'll pay a percentage of the total cost (also called coinsurance) anytime you get care for a covered service. Your plan will cover the rest.

Health Savings Account

An HSA allows you to set aside pre-tax dollars to pay for care when you need it, now or in the future. You can use money in the account to pay for qualified medical expenses like hospital visits, prescription drugs or copays for doctor visit.[1]

- Once you pay your deductible, you'll pay a percentage of the total cost (also called coinsurance) anytime you get care for a covered service. Your plan will cover the rest.
- All the money in your HSA rolls over from year to year, and it's yours even if you change health plans, jobs or retire.
- The money you put into your HSA, any interest you earn and even the money you take out to pay for health care is all tax-free.
- You can contribute up to $3,600 for individuals and $7,200 for families.[1]
- If you're 55 or older you can contribute an extra $1,000 a year.

Watch our HSA Basics video to learn more.

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

Your pharmacy benefits

What your plan will cover

It's easy to get what you need, whether you take medicine every day or only once in a while.

Your pharmacy plan includes:

- One or more drugs lists. Be sure to check for your medications – the brand-name drugs and the generics that are included in your plan.
  - You can find out if the drug you take is included on the **National 4-tier** Drug List by visiting **anthem.com/VA/Nationaltier4**.

How your pharmacy benefits work

You pay your deductible

Before a plan starts to help pay for medicine, you may first pay a set amount out of your pocket. This is your deductible. You'll want to check the plan details to see if it has a:

- **Pharmacy deductible:** You first pay a set amount of drug costs out of your pocket and it's separate from a medical deductible. You have to pay your full pharmacy deductible before your plan starts to share the cost of your medicine.
- **Combined deductible:** You first pay a set amount for both covered medical care and drug costs out of your pocket.
- **No pharmacy deductible:** Your plan helps pay for medicine before you reach your deductible.

You and your plan share the costs

You pay a set amount, or copay, for medicine. Your copay will be based on which tier the drug is on. See Save money with Tier 1 drugs to learn more.

Your pharmacy benefits

Save money with Tier 1 drugs

Prescription medicines or drugs are listed in groups called tiers. Your cost is based on which tier the drug is in. Tiers 1 and 2 usually include low-cost and generic drugs. You'll save the most money when you use Tier 1 drugs.

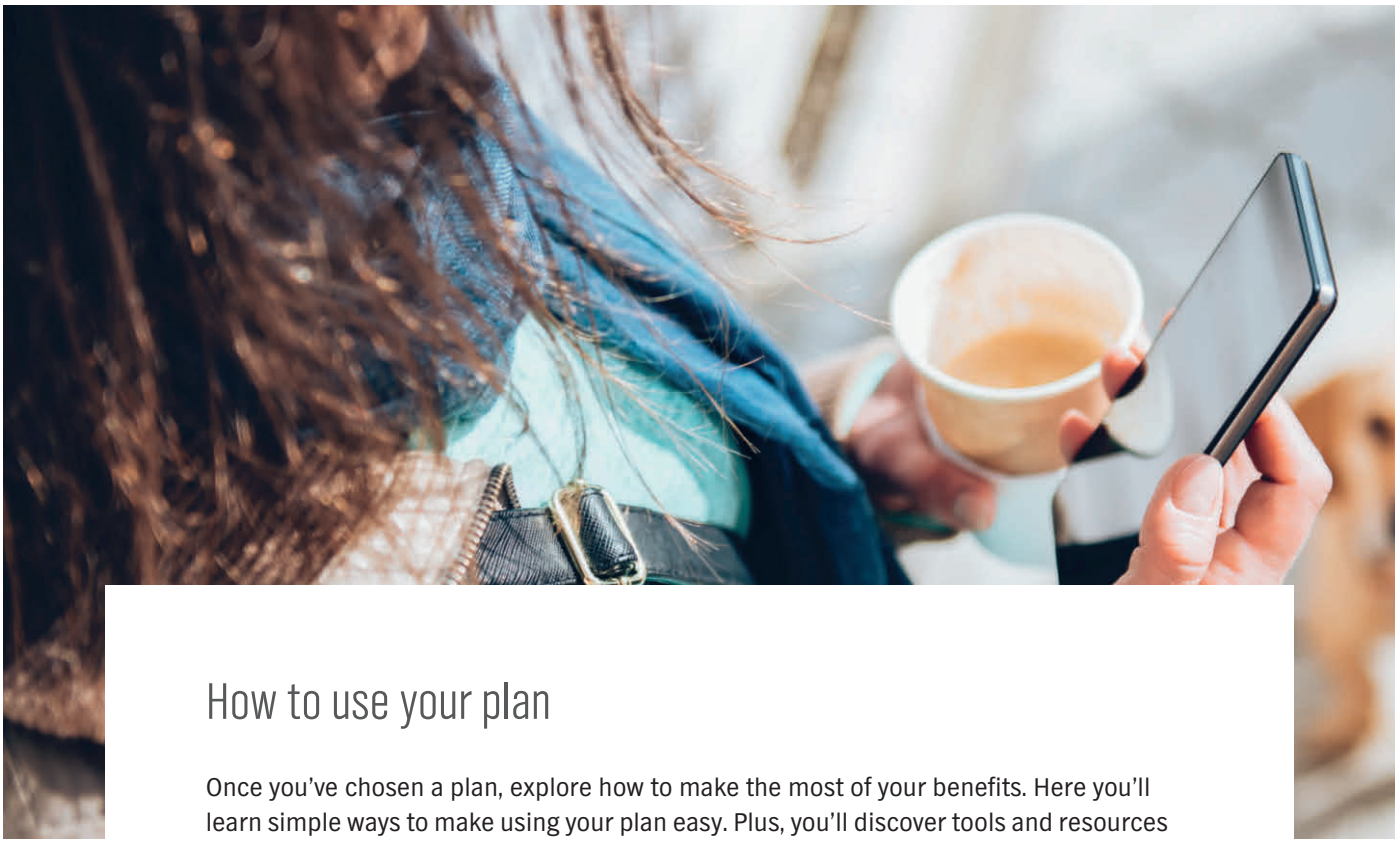
Once you're a member, you can check the price of a drug at different pharmacies at **anthem.com** and see if there are lower-cost drugs.

	Drug type	Cost
Tier 1	Preferred generic	$
Tier 2	Preferred brand name and newer, more expensive generic drugs	$$
Tier 3	Nonpreferred brand name and generic drugs	$$$
Tier 4	Preferred specialty drugs (brand name and generic)	$$$$

Simple ways to save money on medicine

- Find a pharmacy in your plan.
- Talk to your doctor about generic medicines.
- See if an over-the-counter option is available.

Using your plan



How to use your plan

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

How to use your plan

Use your ID card right from your phone

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

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

Register for online tools and resources

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

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- Look at your prescription drug benefits, check the price of a drug and find a pharmacy near you that's in your plan.
- View your claims, see what's covered and what you may owe for care.
- Check your spending account balances.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.

How to use your plan

Find a doctor in your plan

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

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

Schedule a checkup

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

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

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

Make the most of your pharmacy benefits

You can manage your prescriptions and costs at **anthem.com**. Simply log in and explore the following ways to save:

1. **Search the drug list.** Find out if your drugs are covered and which tier they're in. Lower-cost drugs and generics are usually in Tiers 1 and 2. You'll save the most money when you use Tier 1 drugs.
2. **Price a medication.** See how much a medicine costs. 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 pricing.
3. **See if there are generic options.** If you're taking a brand-name drug, you can find a list of generic options that cost less, or ask your doctor.
4. **Choose a pharmacy that's in your plan.** You have many retail pharmacies to choose from. Use a pharmacy that is in your plan to get the best price. To find a pharmacy in your plan, visit **anthem.com/pharmacyinformation/ networks** and choose your network list. Your plan uses the National network list of pharmacies.

Questions?

Call the Pharmacy Member Services phone number on your member ID Card – we're available 24/7.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/fi. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833)592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Calendar Year deductible?	**$3,000**/single or **$6,000**/family ($3,000 Individual) for In-Plan Providers and Out-of-Network Providers combined.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and annual Vision exam for In-Plan Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,000**/single; **$8,000**/family for In-Plan Providers. **$6,000**/single; **$12,000**/family for Out-of-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 Calendar Year out-of-pocket limit?	Premiums, Balance-Billing charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (833)592-9956 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Plan Provider (You will pay the least)	Out-Of-Plan- Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	--------none--------
	Specialist visit	0% coinsurance	20% coinsurance	--------none--------
	Preventive care/screening/ immunization	No cost share	20% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 0% coinsurance X-Ray – Office 0% coinsurance	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$10/prescription (retail) and $25/prescription (home delivery)	$10/prescription (retail) (no home delivery)	***Copays & Coinsurance apply after Deductible.*** In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay. Some drugs may require prior authorization, while other drugs are subject to step therapy and quantity limit requirements. Must use IngenioRx pharmacy. Out of network you'll be responsible for amounts over the allowable.
	Tier 2 - Typically Preferred/ Brand	$30/prescription (retail) and $75/prescription (home delivery)	$30/prescription (retail) (no home delivery)	
	Tier 3 - Typically Non-Preferred	$50/prescription (retail) and $125/prescription (home delivery)	$50/prescription (retail) (no home delivery)	
	Tier 4 - Typically Specialty Drugs (Self-Injectable only)	20% coinsurance up to $200/prescription (retail and home delivery)	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	--------none--------
	Physician/surgeon fee	0% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network*	--------none--------
	Emergency medical transportation	0% coinsurance	Covered as In-Network*	--------none--------
	Urgent care	0% coinsurance	20% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Pre-auth required
	Physician/surgeon fees	0% coinsurance	20% coinsurance	--------none--------

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Plan Provider (You will pay the least)	Out-Of-Plan- Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	0% coinsurance	20% coinsurance	--------none--------
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	100 visits/benefit period.
	Rehabilitation services	0% coinsurance	20% coinsurance	Visit limits apply.
	Habilitation services	0% coinsurance	20% coinsurance	
	Skilled nursing care	0% coinsurance	20% coinsurance	100 day limit/stay.
	Durable medical equipment	0% coinsurance	20% coinsurance	--------none--------
	Hospice services	0% coinsurance	20% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	$15/copay	No charge up to $30/occurrence	One routine exam per calendar year
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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
- Cosmetic surgery
- Long- term care
- Dental care (children & adults)
- Infertility treatment
- Morbid Obesity services
- Hearing aids
- Routine foot care other than for Diabetes
- Weight loss programs

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

- Autism Spectrum Disorder
- Most coverage provided outside the United States www.bcbs.com/bluecardworldwide
- Routine eye care (adult) Coverage is limited to Routine vision exam per calendar year

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

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

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services

Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
RxCopayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,100**

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

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*

Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
RxCopayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,000**

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

The plan's overall deductible	$3,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,010
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,010**

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

Language Access Services:

(TTY/TDD: 711)

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

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

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

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

Bassa (Bǎsɔ́ɔ̀ Wùdù): Ǹ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (833) 592-9956.

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

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (833) 592-9956. သို့ ခေါ်ဆိုပါ။

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

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (833)592-9956.

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

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

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

Language Access Services:

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

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

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

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

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

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

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833)592-9956.

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

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

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (855) 333-5735

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(855) 333-5735 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 333-5735 ។

Language Access Services:

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

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

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833)592-9956

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h ílínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih (833)592-9956.

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

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

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

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

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

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

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 333-5735.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5735.

Language Access Services:

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

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 333-5735.

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

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

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่ายโดยโทร

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

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

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

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833) 592-9956.

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833)592-9956.

Language Access Services:

It's important we treat you fairly

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/aso. For general definitions of common terms, such as **allowed amount, balance billing, coinsurance, copayment, deductible, provider**, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-833-592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Calendar Year deductible?	**$2,000**/member or **$4,000**/family for In-**Network Providers**. **3,000**/ member or **$6,000**/family for Out-of-**Network Providers**.	Generally you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible.**
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care and annual Vision exam for In-Network Providers.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the Medical/Drug out-of-pocket limit for this plan?	**$5,000**/ member or **$10,000**/family for In-**Network Providers**. **$7,250**/ member or **$14,500**/family for Out-of-**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?	Cost share of adult routine vision care, **Premiums**, **Balanced-Billed** charges, and Health Care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call 1-833-592-9956 for a list of **Network Providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.

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Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **coinsurance** costs shown in this chart are after your **deductible** has been met.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	--------none--------
	Specialist visit	$50 copay/visit	40% coinsurance	--------none--------
	Preventive care/**screening**/immunization	No cost share	40% coinsurance	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com	Tier 1 - Typically Generic	$15/prescription (retail) and $38/prescription (home delivery)	$15/prescription (retail) (no home delivery)	Pharmacy member cost shares count towards the combined Medical/Drug out-of-pocket maximum. Most Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply. In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay. Your plan uses a preferred drug list (formulary). **Self-administered Specialty drugs must be dispensed by IngenioRx**. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements.
	Tier 2 - Typically Preferred/ Brand	$40/prescription (retail) and $100/prescription (home delivery)	$40/prescription (retail) (no home delivery)	
	Tier 3 - Typically Non-Preferred Brand	$75/prescription (retail) and $188/prescription (home delivery)	$75/prescription (retail) (no home delivery)	
	Tier 4 - Typically Specialty Drugs (Only self-administered specialty drugs covered under pharmacy benefit. **Clinician/Physician administered specialty drugs are covered under the Medical plan**.)	20% coinsurance up to $200/30 day day fill $400/90 day fill (retail and home delivery)	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	**Emergency room care**	20% coinsurance	20% coinsurance	--------none--------
	Emergency medical transportation	20% coinsurance	20% coinsurance	--------none--------
	Urgent care	$30 PCP/$50 Spec. copay/visit	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit $30 copay/visit Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	--------none--------
	Inpatient services	20% coinsurance	40% coinsurance	Precertification required.
If you are pregnant 24	Office visits	$30 PCP/$50 Spec. copay/visit (non-global billed services)	40% coinsurance	Routine pre/post-natal care (excluding inpatient stay & diagnostic testing). Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasounds).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	**Home health care**	**20% coinsurance**	40% coinsurance	100 visits/per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	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.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 day per stay limit; pre-authorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice service	No cost share	40% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	$15/visit	$30 allowance	One routine exam per calendar year ——————none——————
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care other than for Diabetes
- Weight loss programs
- Morbid Obesity services

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

- Chiropractic care 30 visits/benefit period.
- Adult Routine Eye Exams
- Autism Spectrum Disorder
- Coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

ATTN: Anthem **Grievance** and **Appeals** P.O. Box 27401, Atlanta, Richmond, VA 23279.

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

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

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall *deductible*	$2,000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$150
Coinsurance	$2,138
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,288**

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

The plan's overall *deductible*	$2,000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$900
Coinsurance	$912
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,812**

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

The plan's overall *deductible*	$2,000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,002**

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

Language Access Services:

(TTY/TDD: 711)

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

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

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

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

Bassa (Bǎsɔ̀ɔ̀ Wùdù): M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (833)592-9956

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

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (833)592-9956 သို့ ခေါ်ဆိုပါ။

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

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (833)592-9956.

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

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

Language Access Services:

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

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

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

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

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

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

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

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833)592-9956.

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

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

Language Access Services:

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

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

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

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

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

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833)592-9956.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídíłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojíʼ hodíílnih . (833)592-9956

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

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

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

Language Access Services:

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

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

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

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

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

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

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

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

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

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

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

Language Access Services:

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

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

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833)592-9956.

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833)592-9956.

It's important we treat you fairly

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/aso. For general definitions of common terms, such as **allowed amount, balance billing, coinsurance, copayment, deductible, provider**, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833)592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Calendar Year deductible?	**$0**/member or **$0**/family for In-Network Providers. **$500**/ member or **$1,000**/family for Out-of-Network Providers.	Generally you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care and annual Vision exam for In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the Medical/Drug out-of-pocket limit for this plan?	**$5,000**/ member or **$10,000**/family for In-Network Providers. **$6,500**/ member or **$13,000**/family for Out-of-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?	Cost share of adult routine vision care, Premiums, Balanced-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (833)592-9956for a list of Network Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **coinsurance** costs shown in this chart are after your **deductible** has been met.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	30% coinsurance	--------none--------
	Specialist visit	$50 copay/visit	30% coinsurance	--------none--------
	Preventive care/**screening**/immunization	No cost share	30% coinsurance	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.express-scripts.com	Tier 1 - Typically Generic	$15/prescription (retail) and $38/prescription (home delivery)	$15/prescription (retail) (no home delivery)	Pharmacy member cost shares count towards the combined Medical/Drug out-of-pocket maximum. Most Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply. In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay. Your plan uses a preferred drug list (formulary). **Self-administered Specialty drugs must be dispensed by IngenioRx** Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements.
	Tier 2 - Typically Preferred/ Brand	$40/prescription (retail) and $100/prescription (home delivery)	$40/prescription (retail) (no home delivery)	
	Tier 3 - Typically Non-Preferred Brand	$75/prescription (retail) and $188/prescription (home delivery)	$75/prescription (retail) (no home delivery)	
	Tier 4 - Typically Specialty Drugs (Only self-administered specialty drugs covered under pharmacy benefit. **Clinician/Physician administered specialty drugs are covered under the Medical plan.**)	20% coinsurance up to $200/30 day day fill $400/90 day fill (retail and home delivery)	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay+20% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	No cost share	30% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay+20% coinsurance	20% coinsurance	--------none--------
	Emergency medical transportation	$150 copay/transport	20% coinsurance	--------none--------
	Urgent care	$30 PCP/$50 Spec. copay/visit	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay+20% coinsurance	30% coinsurance	Precertification required.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit $30 copay/visit Other Outpatient 20% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	--------none--------
	Inpatient services	$300 copay+20% coinsurance	30% coinsurance	Precertification required.
If you are pregnant	Office visits	$200 copay/pregnancy (global billed services)	30% coinsurance	$200 copay for OB Dr. global billed services covering pre- and post-natal care and delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasounds).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	$300 copay+20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	30% coinsurance	100 visits/per calendar year.
	Rehabilitation services	**Physical Therapy**: $50 copay+ 20% coinsurance **Speech/Occupational Therapy:** 20% coinsurance	30% coinsurance	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.
	Habilitation services	Same as above	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	100 day per stay limit; pre-authorization required.
	Durable medical equipment	20% coinsurance	30% coinsurance	————————none————————
	Hospice service	No cost share	30% coinsurance	————————none————————
If your child needs dental or	Children's eye exam	$15/visit	$30 allowance	One routine exam per calendar year
	Children's glasses	Not covered	Not covered	————————none————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
eye care	Children's dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

Acupuncture
Cosmetic surgery
Dental care
Hearing aids
Infertility treatment
Long-term care
Routine foot care other than for Diabetes
Weight loss programs
Morbid Obesity services

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

Chiropractic care 30 visits/benefit period.
Adult Routine Eye Exams
Autism Spectrum Disorder
Coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
Routine eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

ATTN: Anthem **Grievance** and **Appeals** P.O. Box 27401, Atlanta, Richmond, VA 23279.

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

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

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall *deductible*	$00
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$2,478
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,928**

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

The plan's overall *deductible*	$0
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$1,312
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,212**

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

The plan's overall *deductible*	$0
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$362
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$562**

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

Language Access Services:

(TTY/TDD: 711)

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

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

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

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

Bassa (Bǎsɔ̀ɔ̀ Wùdù): M̀ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bɛ́ m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (833)592-9956.

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

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (833)592-9956 သို့ ခေါ်ဆိုပါ။

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

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (833)592-9956.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 451-1527.

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 451-1527 تماس بگیرید.

Language Access Services:

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

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

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

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

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

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

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

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833)592-9956.

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

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

Language Access Services:

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

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

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

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

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

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833)592-9956

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídíłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojíʼ hodíílnih (833)592-9956.

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

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

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

Language Access Services:

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

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

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

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

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

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

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

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

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

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได ้รับความช่วยเหลือและข ้อมูลในภาษาของท่านโดยไม่มีค่าใช ้จ่าย โดยโทร (833)592-9956 เพื่อพูดคุยกับล่าม

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

Language Access Services:

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

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

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833)592-9956 .

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833)592-9956.

It's important we treat you fairly

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

Anthem Medical Plans effective January 1, 2021

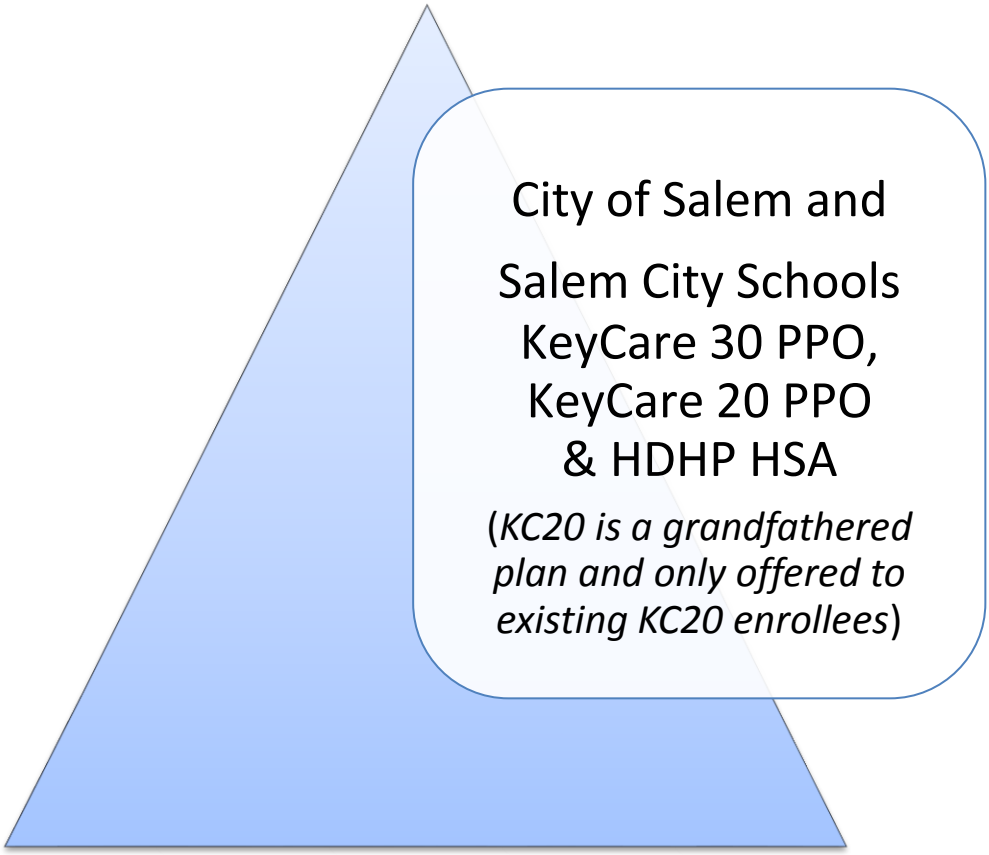
- Keycare 30 PPO with $15/$40/$75/20% drug plan
- HDHP HSA with $10/$30/$50/20%, after deductible drug plan

All plans use the KeyCare PPO/BCBS PPO Bluecard National network of providers.

All Medical plans include the following:

- Preventive Care services covered with no Member cost share when using in-network providers. Please note any services that are not done and/or billed as Preventive Care classified services will be considered as Diagnostic services and subject to regular plan provisions/benefit levels.
- An annual calendar year routine eye exam for a $15 copay when using a BlueView Vision (BVV) participating provider. The BVV program also offers discounts on frames and lenses.

Summary of Benefits



Effective January 1, 2021

Lumenos HSA-HDHP $3,000 Embedded Deductible

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	**No cost share***
Routine Vision	
o annual routine eye exam ***Plus – valuable discounts on eyewear*** If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $3,000 deductible) and you will pay the rest of what the professional charges.	**$15** for each visit
Annual Deductible	
Your deductible is combined for In-network and Out-of-Network services. o For single coverage, you will pay all the costs associated with your care until you have paid $3,000 in one calendar year. o If two people are covered under your plan, each of you will pay the first $3,000 of the cost of your care ($6,000 total). o If three or more people are covered under your plan, together you will pay the first $6,000 of the cost of your care. However, the most one family member will pay is $3,000. **In-Network Services** Once you have reached this amount, you will pay the amounts designated in the "you pay" column below. **Out-of-Network Services** For covered services to out-of-network providers, you will pay 20%. However, it's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts.	
Once you reach your deductible, you will pay the following for covered in-network services	
All Other In-Network Services	**You Pay**
Doctor Visits	
o office visits o urgent care visits o home visits o pre- and postnatal office visits o mental health and substance use visits o in-office surgery o physical and occupational therapy in an office setting (90 combined visits)* o speech therapy visits in an office setting (90 visit limit)* o spinal manipulations and other manual medical intervention visits (30 visit limit) * ***Limit does not apply to Autism Spectrum Disorder.***	**0%** of the amount the health care professionals in our network have agreed to accept for their services
Labs, Diagnostic X-rays and Other Outpatient Services	
o diagnostic lab services o shots and therapeutic injections o medical appliances, supplies and medications, including infusion medications o diagnostic x-rays o dialysis o ambulance travel o durable medical equipment o chemotherapy (not given orally), radiation, cardiac and respiratory therapy	**0%** of the amount the health care professionals in our network have agreed to accept for their services

In-Network Services	You Pay
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** ** ***Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o unlimited per member annual maximum	**0%** of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (90 combined visits)* o speech therapy (90 visit limit)* o surgery o emergency room o physician services o mental health and substance use partial-day treatment programs * ***Limit does not apply to Autism Spectrum Disorder.***	**0%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o private duty nursing is limited to 16 hours per member per calendar year* ****Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.***	**0%** of the amount the health care professionals in our network have agreed to accept for their services
o home health care (100 visits) o hospice care	**0%** of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services o skilled nursing facility care (180 days for each admission)	**0%** of the amount the health care professionals in our network have agreed to accept for their services
Retail or Specialty Pharmacy	**After Deductible**
o Up to a 30-day medication supply at participating pharmacies *Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.*	Tier 1 **$10** Tier 2 **$30** Tier 3 **$50** Tier 4 **20% up to $200/script**
Home Delivery	**After Deductible**
o Up to a 90-day medication supply delivered to your home *Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.*	Tier 1 **$25** Tier 2 **$75** Tier 3 **$125** Tier 4 **N/A**
Retail Maintenance	**After Deductible**
o Up to a 90-day medication supply at participating pharmacies	Tier 1 **$30** Tier 2 **$90** Tier 3 **$150** Tier 4 **N/A**

Your benefit period is a calendar year. A calendar year means your benefit period runs from January 1 through December 31).

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

Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Calendar Year
When using network professionals For single coverage, you will pay $4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. o If two people are covered under your plan, each of you will pay $4,000 ($8,000 total). o If three or more people are covered under your plan, together you will pay $8,000. However, no family member will pay more than $4,000 toward the limit. **When not using network professionals** For single coverage, you will pay $6,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. o If two people are covered under your plan, each of you will pay $6,000 ($12,000 total). o If three or more people are covered under your plan, together you will pay $12,000. However, no family member will pay more than $6,000 toward the limit. The following do not count toward the calendar year out-of-pocket maximum: o your share of the cost of adult routine vision care o the cost of care received when the benefit limits have been reached o the cost of services and supplies not covered under your benefits o the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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

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

Your prescription drug plan

Lumenos HDHP-HSA

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum. Please refer to the benefit summary included with your enrollment brochure for the out-of-pocket maximum established for your medical and pharmacy benefit.

30-Day Retail Pharmacy Network

Our network includes more than 69,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

Retail 90 Pharmacy

Retail 90** is a unique network that offers more ways for you to get the maintenance medications you need. Maintenance medications are drugs taken on an ongoing basis for conditions such as asthma, diabetes or high cholesterol. Through Retail 90, you can choose to get a 90-day supply of medications from a participating retail pharmacy.

**Approximately 98% of the pharmacies in our network participate in the Retail 90 program. Be sure to check with your local pharmacy to verify their participation status prior to placing your 90 day retail prescription order.

To make sure your pharmacy's in our network, visit anthem.com and select Find a Doctor which will take you to the list of providers, pharmacies and hospitals who participate in our network.

Home Delivery Pharmacy

Members needing maintenance medications also have the option to use our Home Delivery Pharmacy service. Our preferred Home Delivery Pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- 90-day maintenance medications for less cost than if you purchased them at a retail location
- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Ordering refills
With home delivery, you don't have to worry about running out of medication. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

Specialty Pharmacy

IngenioRX specialty pharmacy, provides support and medicine for people with complex, long-term conditions. Most specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail (Transplant and HIV/AIDS medications are covered up to a 90 day supply). They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn's Disease
- Growth Hormone
- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Your prescription drug plan (continued)

Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from yourtreatments. You may be connected with a nurse fromour Speciality Condition Management program. This rare disease management program connects you with nurses who will help with questions about medications or managing your disease. In addition, pharmacists, socialworkers and other key members of the Care Team are available to help answer your questions.

Drug list *(Anthem Preferred Drug List 4-Tier)*

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs. We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit **anthem.com**. Click on "Find a doctor" then scroll down to "Medication Search". If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Preferred Generics

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of a brand drug – but usually at a lower cost.

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

Step Therapy

Step Therapy may be required for certain drugs. Step Therapy refers to the process in which you may be required to use one type of medication before benefits are available for another. Step Therapy helps you and your doctor chose drugs that are safe, affordable and right for you. When your doctor prescribes a drug that requires step therapy, a message is sent to your pharmacy. This lets the pharmacist know you must first try a different, similar drug that's covered by your plan. The pharmacist will call your doctor to get a prescription for the new drug.

Quantity Limit

Taking too much medicine or using it too often isn't safe. And it may even drive up your health care costs. That's why your plan may limit the amount of medicine that's covered for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you.

Your prescription drug plan (continued)

Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

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. Anthem Blue Cross and Blue Shield and its affiliates, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association.®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

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

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

Anthem KeyCare 30 PPO Plan: $2,000 In-Network Deductible

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	**No cost share**
Routine Vision	
o annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit
Doctor Visits	
o office visits o urgent care visits o pre- and postnatal office visits* o home visits ***If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)***	**$30** for each visit to a PCP **$50** for each visit to a specialist
o online visits (https://livehealthonline.com) (does not include livehealthonline mental health/substance abuse therapist visits)	**$20** for each visit
o mental health and substance abuse office visit (including livehealthonline therapist visits)	**$30** for each visit
o spinal manipulation and other manual medical intervention visits (30 visit limit)	**$25** for each visit
All Other In-Network Services	**You Pay**
You will pay all the costs associated with care until you have paid $2,000 in one calendar or plan year. This is known as your deductible. o If two people are covered under your plan, each of you will pay the first $2,000 of the cost of your care ($4,000 total). o If three or more people are covered under your plan, together you will pay the first $4,000 of the cost of your care. However, the most one family member will pay is $2,000. **Once you reach your deductible you pay:**	
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** ****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o shots and therapeutic injections o medical appliances, supplies and medications, including infusion medications o durable medical equipment o diagnostic lab services o ambulance travel o chemotherapy (not given orally), IV, radiation, cardiac and respiratory therapy o physical and occupational therapy visits in an office setting (30 combined visits)* o speech therapy visits in an office setting (30 visit limit)* o dialysis o diagnostic x-rays ***Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services

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

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

In-Network Services	You Pay
Other Outpatient Services - Continued	
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Outpatient Services in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* o partial day mental health and substance abuse services o emergency room o surgery ***Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care (100 visits)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o hospice care	**No cost share**
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services. o skilled nursing facility care (100 days for each admission)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Out-of-Network Services	
Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits	
It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $3,000 in one calendar year. This is called your out-of-network deductible. o If two people are covered under your plan, each of you will pay the first $3,000 of the cost of your care ($6,000 total). o If three or more people are covered under your plan, together you will pay the first $6,000 of the cost of your care. However, the most one family member will pay is $3,000. Once you have reached this amount, when you receive covered services we will pay 60% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $3,000 out-of-network deductible) and you will pay the rest of what the professional charges.	
Out-of-Pocket Maximums	
What You Will Pay for Covered Services in One Calendar Year	

When using network professionals
If you are the only one covered by your plan, you will pay $5,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay $5,000 ($10,000 total).
- If three or more people are covered under your plan, together you will pay $10,000. However, no family member will pay more than $5,000 toward the limit.

When not using network professionals
If you are the only one covered by your plan, you will pay $7,250 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay $7,250 ($14,500 total).
- If three or more people are covered under your plan, together you will pay $14,500. However, no family member will pay more than $7,250 toward the limit.

The in-network calendar year out-of-pocket maximum includes in-network medical copays, deductible, coinsurance, and in-network pharmacy copays & coinsurance.

***The following do not count toward the calendar year out-of-pocket maximum:**
- your share of the cost of routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 30 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the federal health care reform laws. Anthem believes the benefits are compliant with applicable law, but they have not been approved by the Virginia Bureau of Insurance at this time. We may be required to make additional changes to this summary of benefits

Anthem KeyCare 20 PPO Plan: $0 In-Network Deductible

(Grandfathered plan, only available to existing KC20 enrollees)

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	***No cost share**
Routine Vision	
o annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit
Doctor Visits	
o office visits o urgent care visits o home visits o spinal manipulations and other manual medical intervention visits (30 visit limit) o in office surgery	**$30** for each visit to a PCP **$50** for each visit to a specialist
o online visits (**www**.livehealthonline.com) (doesn't include livehealthonline mental health/substance abuse therapist visit)	**$20** for each visit
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** ** ***Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
o unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Labs, Diagnostic X-rays and Other Outpatient Services	
o diagnostic lab services o diagnostic x-rays o dialysis o infusion services o shots and therapeutic injections, including infusion medications o chemotherapy (not given orally), radiation, cardiac and respiratory therapy	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
o durable medical equipment	**20%** of the amount the health care professionals in our network have agreed to accept for their services.
o ambulance travel	**$150** copayment per transport

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-network).

In-Network Services	You Pay
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* ***Limit does not apply to Early Intervention and Autism Spectrum Disorder.***	**PT - $50 copay plus 20%** of the amount the health care professionals in our network have agreed to accept for their services; **OT and ST**, **20%** of the amount the health care professionals in our network have agreed to accept for their services.
o surgery ***For the services billed by the doctor, you will pay an additional $30 or $50 depending on the type of doctor who treats you.***	**$200 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
Emergency Care	
o emergency room	**$200 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*
o emergency room physician services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Mental Health and Substance Abuse Outpatient Services	
o office visits	**$30 for each visit**
o outpatient facility (including partial day mental health and substance abuse services) o outpatient facility professional provider services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o hospice care	**No cost share**
o home health care (100 visits)	**$30** copay per visit
Maternity	
o all routine pre- and postnatal care (excluding inpatient stays)	**$200** per pregnancy
o diagnostic test o non-stress tests and other fetal monitor procedures o ultrasounds	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit ***You do not have to pay another inpatient copay if you are readmitted for the same or related condition within 90 days of the day you went home.***	**$300 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services*
o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services	**20%** of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $400 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $500 of the cost of your care ($1,000 total).
- If three or more people are covered under your plan, together you will pay the first $1,000 of the cost of your care. However, the most one family member will pay is $500.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $400 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

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

When using network professionals

If you are the only one covered by your plan, you will pay $5,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay $5,000 ($10,000 total).
- If three or more people are covered under your plan, together you will pay $5,000. However, no family member will pay more than $5,000 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay $6,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay $6,500 ($13,000 total).
- If three or more people are covered under your plan, together you will pay $13,000. However, no family member will pay more than $6,500 toward the limit.

The in-network calendar year out-of-pocket maximum includes in-network medical copays and coinsurance, and in-network pharmacy copays & coinsurance.

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

- your share of the cost routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 20 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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

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

Your prescription drug plan

KeyCare 20 PPO and KeyCare 30 PPO Prescription Drug program

Your Prescription Drug 15-40-75-20% Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay	Tier 4 Copay
Up to a 30-day medication supply at participating pharmacies	$15	$40	$75	20% coinsurance with a $200 prescription maximum*
Up to a 90-day medication supply delivered to your home	$38	$100	$188	Not Applicable
Up to a 90-day medication supply purchased at a participating** retail pharmacy	$45	$120	$225	Not Applicable
**Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.*				

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum. Please refer to the benefit summary included with your enrollment brochure for the out-of-pocket maximum established for your medical and pharmacy benefit.

30-Day Retail Pharmacy Network

Our network includes more than 69,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

Retail 90 Pharmacy

Retail 90** is a unique network that offers more ways for you to get the maintenance medications you need. Maintenance medications are drugs taken on an ongoing basis for conditions such as asthma, diabetes or high cholesterol. Through Retail 90, you can choose to get a 90-day supply of medications from a participating retail pharmacy.

**Approximately 98% of the pharmacies in our network participate in the Retail 90 program. Be sure to check with your local pharmacy to verify their participation status prior to placing your 90 day retail prescription order.

To make sure your pharmacy's in our network, visit anthem.com and select Find a Doctor which will take you to the list of providers, pharmacies and hospitals who participate in our network.

Home Delivery Pharmacy

Members needing maintenance medications also have the option to use our Home Delivery Pharmacy service. Our preferred Home Delivery Pharmacy, managed by IngenioRX, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- 90-day maintenance medications for less cost than if you purchased them at a retail location
- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Ordering refills
With home delivery, you don't have to worry about running out of medication. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

Your prescription drug plan (continued)

Specialty Pharmacy

IngenioRx specialty pharmacy, provides support and medicine for people with complex, long-term conditions. Most specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail (Transplant and HIV/AIDS medications are covered up to a 90 day supply). They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn's Disease
- Growth Hormone
- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments. You may be connected with a nurse from our Speciality Condition Management program. This rare disease management program connects you with nurses who will help with questions about medications or managing your disease. In addition, pharmacists, socialworkers and other key members of the Care Team are available to help answer your questions.

Drug list *(Anthem Preferred Drug List 4-Tier)*

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs. We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit **anthem.com**. Click on "Find a Doctor" then scroll down to "Medication Search". If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Preferred Generics

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of a brand drug – but usually at a lower cost.

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

Your prescription drug plan (continued)

Step Therapy

Step Therapy may be required for certain drugs. Step Therapy refers to the process in which you may be required to use one type of medication before benefits are available for another. Step Therapy helps you and your doctor chose drugs that are safe, affordable and right for you. When your doctor prescribes a drug that requires step therapy, a message is sent to your pharmacy. This lets the pharmacist know you must first try a different, similar drug that's covered by your plan. The pharmacist will call your doctor to get a prescription for the new drug.

Quantity Limit

Taking too much medicine or using it too often isn't safe. And it may even drive up your health care costs. That's why your plan may limit the amount of medicine that's covered for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you.

Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

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

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

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

Blue View Vision℠

City of Salem and Schools
Exam Only A15 Plan

Anthem
And Its Affiliate HealthKeepers, Inc.

Welcome to your Blue View Vision plan!

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

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

USING YOUR BLUE VIEW VISION PLAN

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

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

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

OUT-OF-NETWORK

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

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
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		Member Pays
Retinal Imaging	• At member's option can be performed at time of eye exam	Not more than $39
Eyeglass Frame	• When purchased as part of a complete pair of eyeglasses*	35% off retail price
Eyeglass Lenses Standard plastic material	• When purchased as part of a complete pair of eyeglasses*: - Single Vision - Bifocal - Trifocal	 $50 $70 $105
Eyeglass Lens Options and Upgrades When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	• When purchased as part of a complete pair of eyeglasses*: - UV Coating - Tint (Solid and Gradient) - Standard Scratch-Resistant Coating - Standard Polycarbonate - Standard Anti-Reflective Coating - Standard Progressive Lenses (add-on to Bifocal) - Other Add-Ons	 $15 $15 $15 $40 $45 $65 20% off retail price
Conventional Contact Lenses (non-disposable type)	• Discount applies to materials only	15% off retail price

* 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 · contactsdirect · LensCrafters · Pearle Vision · Target Optical · Sears Optical · JCPenney optical

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.

The savvy member's action guide

Smart ideas to get more out of your health plan

Little things make a big difference

You can make the most of your benefits and save money with these easy tips. See more details on **anthem.com** or the Sydney mobile app.

Savvy ways to keep costs down

Tip #1: Use our Care & Cost Finder tool

Different providers may charge different amounts for the same services, such as MRIs and surgeries. Getting estimates, based on your plan benefits, can save you a lot before you ever set foot in a doctor's office or hospital. Start researching costs on **anthem.com**.

Tip #2: Make sure your doctor and other providers are in your plan

If you're not sure:

- Use the Find a Doctor tool on **anthem.com** to check or search for a doctor near you.
- Ask the facility if each provider is contracted with our network.
- Call Member Services to request a list of providers or use the Sydney mobile app to confirm the provider is in our network.

Tip #3: Review your explanation of benefits (EOB)

Your EOB is your personal claim/coverage report and should list the care you've received. You can view your EOB at **anthem.com** or on the Sydney mobile app. If you ever have EOB questions, call the Member Services number on your member ID card.

Savvy places to save on quality care

Tip #1: Access doctors online, 24/7

LiveHealth Online allows you to talk to board-certified primary care doctors, psychologists and psychiatrists by two-way video for the cost of an office visit copay. You can schedule an appointment with a psychologist or psychiatrist, or live chat with a primary care doctor 24/7. Register at **livehealthonline.com**.

Tip #2: Ask about your radiology and lab service options

We give your doctors quality and cost data for radiology centers in your area to help them choose the right one for you. You can also lower your out-of-pocket costs by visiting a freestanding lab for things like blood and urine tests.

Download the Sydney mobile app
from the App Store® or Google Play™ to access your ID card, find a plan doctor and much more.

Download on the App Store

ANDROID APP ON Google play

Savvy programs for prevention and well-being

Tip #1: Get preventive care

You're covered 100% for checkups, flu shots and certain cancer screenings. To learn more, visit the *Preventive Health* section on **anthem.com** or log in to the Sydney mobile app. And ask your doctor about preventive versus. diagnostic care to avoid surprise costs.

Tip #2: Understand the difference between preventive care and diagnostic care

Routine screenings are considered "preventive" and fully covered by your plan. If your doctor finds a problem that requires more testing or you're following up on an existing issue, the visit becomes "diagnostic" and you'll need to pay your regular cost share.

Tip #3: Take advantage of health and wellness programs

Get support for an ongoing medical condition, call the 24/7 NurseLine with questions or work with a coach to meet personal health goals. These resources are all part of your plan at no extra cost. Some of our other health and wellness offerings include:

- **Health Record:** Regularly update and store your health history in one secure place. Then, share it with your doctor to make sure you're on the same page. You can create your Health Record on **anthem.com**.
- **SpecialOffers:** Enjoy discounts on products and services that promote well-being. Visit **anthem.com** to start saving.
- **The Weight Center:** This website focuses on weight management, good eating habits and emotional health. It includes links to a BMI calculator, the *Weight Management Playbook*, FitLife podcasts and helpful articles. Visit **anthem.com/theweightcenter** to get started.

Savvy alternatives for prescriptions

Tip #1: Shop around for the lowest drug costs

You don't have to buy your medicines from one place, so compare costs before filling prescriptions. Log in to **anthem.com** or the Sydney mobile app to research how medicine is covered under your benefit plan — as well as therapeutic alternatives.

Tip #2: Choose generic and over-the-counter drugs when you can

They're as safe and effective as brand-name drugs, but usually cost much less. Ask your doctor if either makes sense for you.

Tip #3: Look into our special pharmacy programs

Programs like GenericSelect can lower your copay or coinsurance. Call the pharmacy number on your ID card to see if you qualify.

Tip #4: Save time by getting your maintenance prescriptions mailed to you

For cost savings and convenience, most benefit plan options offer home delivery when you get up to a 90-day supply of maintenance medications.

Register today at anthem.com or download the Sydney mobile app

Explore and sign up on anthem.com to give us your communication preferences and get information about your care options, costs, and ways to take control of your health.

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LiveHealth Online

How to register in minutes before you feel sick

Using LiveHealth Online, you can have a private and secure video visit with a board-certified doctor 24/7 on your smartphone, tablet or computer with a webcam. It's a quick and easy way to get the care you need with no appointments or long wait times.

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

Anthem LiveHealth® ONLINE

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How to get started

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

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

Your account securely stores your personal and health information

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

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

Questions about how to use LiveHealth Online?

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

1 Prescription availability is defined by physician judgment and state regulations. Visit the home page of livehealthonline.com to view the service map by state.

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

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

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

Looking for a doctor?

Finding one online is fast and easy

My health.
My plan.

Your health is an important personal matter. So it's just as important to find a main doctor who can be your primary care provider or primary care physician (PCP) — someone you see for regular checkups and when you're sick. Your PCP takes care of your overall health and can recommend a specialist if you need one.

Finding a PCP in your plan

With your Anthem plan, you get access to a large network of doctors across the country — so you have more choices when selecting your PCP. And finding a PCP who's "in-network" or in your plan is easier with our online tools. You can search for a doctor by name or look for one near you. Avoid getting care from doctors outside your plan because it will likely cost you more, or your plan may not cover it at all.

Here's what you need to do:

1. Go to **anthem.com/find-doctor**.
2. Choose your search:
   - **Search as a Member:** Use your member ID card number or log in with a user name and password.
   - **Search as a Guest:** Select a plan or network,* or search by all plans and networks, to get started.
3. Select a type of doctor and location. You can also search within a certain distance of your location.

Looking for cost information to go with your care? Use the **Care & Cost Finder** tool at **anthem.com**. You can compare doctors and costs side by side and get an estimate of what you'll pay based on your benefits. You can even see how other members rate doctors.

To learn more about choosing a doctor, read the Anthem blog, "4 Tips to Choosing the Right Doctor" at **anthem.com/blog**.

On-the-go convenience

Use your mobile device to search for doctors using our free Sydney mobile app from the App Store®or Google Play™.

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* If you don't know the name of the plan or network, check with your human resources department or benefits administrator.

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Anthem

Say hi to Sydney

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

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

Get started with Sydney
Download the app today!

GET IT ON Google Play

Download on the App Store

Simple

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

Smart

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

Personal

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

With just one click, you can:

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

Already using one of our apps?

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

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Choose an easier way to better health

Health and wellness programs designed for your unique needs

Whether you're suffering from asthma, expecting a baby or just fighting a cold, our health and wellness programs can help.

ConditionCare

If you have asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart disease or heart failure, ConditionCare can give you the tools and resources you need to take charge of your health. You'll get:

- 24/7, toll-free phone access to nurses who can answer health questions.
- Support from nurse care managers, dietitians and other health care professionals to help you reach your health goals.
- Educational guides, electronic newsletters and tools to help you learn more about your condition(s).

Future Moms

Having a baby is an exciting time! Future Moms can help you have a healthy pregnancy and a healthy baby. Sign up as soon as you know you're pregnant. You'll get:

- A nurse specializing in obstetrics who can answer your questions, 24/7, and will call to check on your progress.
- The *Mayo Clinic Guide to a Healthy Pregnancy*, which explains the changes your body and baby are going through.
- A screening to check your health risks.
- Resources to help you make healthier decisions during pregnancy.
- Free phone access to pharmacists, nutritionists and other specialists, if needed.
- Other helpful information on labor and delivery, including options and how to prepare.

24/7 NurseLine

Whether it's 3 a.m. or a lazy Sunday afternoon, you can talk to a registered nurse any time of the day or night.

These nurses can:

- Answer questions about health concerns.
- Help you decide where to go for care when your doctor, dentist, or eye doctor isn't available.
- Help you find providers and specialists in your area.
- Enroll you and your dependents in health management programs.
- Remind you about scheduling important screenings and exams, including dental and vision check ups.

Get the support you need

Call us to sign up and use these programs at no extra cost:

- ConditionCare: 866-960-0812
- Future Moms: 800-828-5891
- 24/7 NurseLine: 800-337-4770

Anthem

And Its Affiliate HealthKeepers, Inc.

MVASH1316A VPOD Rev. 7/18

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.

The ins and outs of coverage

(continued)

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

Renewed	Canceled	Changed	When
●			Your employer: ○ Keeps its status as an employer. ○ Stays in our service area. ○ Meets our guidelines for employee participation and premium contribution. ○ Pays the required health care premiums. ○ Doesn't commit fraud or misrepresent itself.
	●		Your employer: ○ Makes a bad payment. ○ Voluntarily cancels coverage (30-days advance written notice required). ○ Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan. ○ Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	●		○ We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice). ○ We decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		●	You and your employer received a 30-day advance written notice that the coverage was being changed (services were added to your plan or the copays were lowered). Copays can be increased or services can be decreased only when it is time for your group to renew its coverage.

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

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

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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

Determining the primary and secondary plans

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

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

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered (Large Group PPO)

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

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

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), physical therapist technicians, and athletic trainers.

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

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

11) **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**.**

12) **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.

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 as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

The following exclusion pertains to those groups that qualify to opt out:

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

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 Anthem.

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.

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

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

    If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

39) **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.

40) **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.

41) **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.

42) **Home 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.

43) **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.

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

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

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

47) **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.

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

   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.

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

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

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

52) **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.

53) **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.

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

55) **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) Hypo-allergenic 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.

56) **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 Care Services" benefit.

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

58) **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.

59) **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.

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

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

The following exclusion pertains except for those groups that qualify to opt out:

62) **Sterilization** Services to reverse elective sterilization.

The following exclusion pertains for those groups that qualify to opt out:

63) **Sterilization** For female sterilization or reversal of sterilization.

64) **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).

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

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

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

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

69) **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.

70) **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.

71) **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.

72) **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.

73) **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. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
5. **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.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **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.
8. **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.
9. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
10. **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.
11. **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.
12. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

    This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
13. **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.
14. **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" benefit. Please see that section for details.
15. **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.
16. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
17. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
18. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the

"Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.

19. **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.
20. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
21. **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.
22. **Non-approved Drugs** Drugs not approved by the FDA.
23. **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.
24. **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.
25. **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.
26. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immune-compromised or diabetic.
27. **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.
28. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
29. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
30. **Weight Loss Drugs** Any Drug mainly used for weight loss.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment and upon renewal. If you have questions, please ask your group administrator or broker.

ABCBS-VA-LG-PPO-COC (1/20)

The legal stuff we're required to tell you

How we keep your information safe and secure

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

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

How we help manage your care

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

To learn more about how we help manage your care, go to **anthem.com/memberrights**. 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 like 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 got married, 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 get help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

Get the full details

Read your ***Certificate of Coverage***, which spells out all the details about your plan. You can it find on **anthem.com**.

Notes

Notes

Ready to use your plan?

Get some extra help

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

Anthem

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