

■ Ready to choose *your benefits?*

We can point you in the right direction.

City of Salem and Salem City Schools
Anthem Medical Plan Options
Effective January 1, 2019



Let's take a look

We know picking a health plan is a big deal, so this guide makes it easier for you to understand your benefit options. We'll explain how the plans work and give you other important details. That way you can enroll with confidence!

In this guide, you'll find:

- The plans at a glance
- Your health care basics
- How to use your health plan
- Your pharmacy benefits
- Health and wellness programs
- Your privacy and rights

Pay a visit to [anthem.com](https://www.anthem.com) to get an idea of what you can do once you're a member. Find a doctor, estimate care costs, sign up to get emails instead of mail and much more!





The plans at a glance

Here's a quick overview of the plans your employer is offering.¹ To learn more plan basics visit [anthem.com/basics](https://www.anthem.com/basics).

KeyCare PPO

- This plan covers services from almost any doctor or hospital.
- You pay less if you use a doctor from the **Preferred Provider Organization** (PPO) plan.
- You pay more if you go to a doctor who's not part of the PPO plan.
- You don't usually need a referral from your main doctor, also called a primary care doctor, to see a specialist.

Lumenos HDHP -HSA

- This plan comes with a **Health Savings Account** (HSA) you can use to pay your deductible or other qualified health care expenses, like prescription drugs or eyeglasses.²
- Once you pay your deductible, you'll pay a percentage of the total cost (also called coinsurance), and your plan covers the rest.
- The money you put into your account isn't taxed – so each dollar goes further. You can contribute up to \$3,500 for individuals and \$7,000 for families to your account.
- If you don't use all the money in your HSA, you can roll over that money to the next year. And you can take it with you if you leave your employer or change health plans.



It's easy to get care in your plan

You can find doctors, hospitals, pharmacies and other health care professionals in our plans on [anthem.com](https://www.anthem.com) – and they charge our members lower rates.

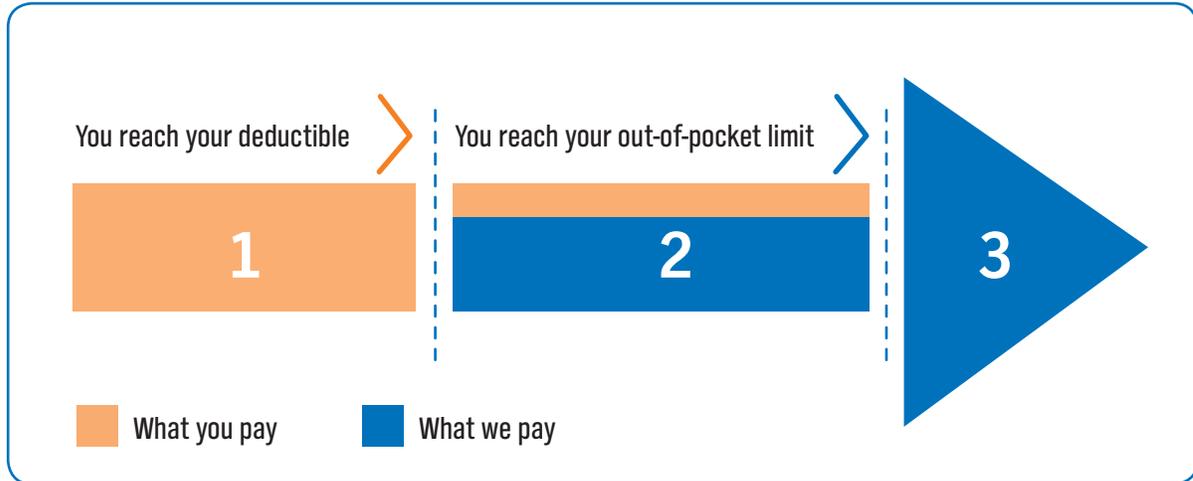
¹ Each of our plans may have different rules, so always check your plan details for more specific information.

² For a full list of qualified expenses visit [irs.gov/pub502](https://www.irs.gov/pub502). 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](https://www.irs.gov/irb/2004-33/IRB) for more information.



Know your health care basics

Learn about the kinds of costs you'll share with your plan



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

You pay your deductible.

This is a set amount that you pay before we start sharing in the cost of the covered health care you receive. If your plan has copays (flat fees like \$30 for each visit) along with a deductible, you only need to pay the copay for most doctor visits.

If you choose a plan with a Health Savings Account, you can use the money in your account to pay towards your deductible.

What happens after I pay my deductible?

You pay a copay or a percentage of the cost, also called coinsurance, each time you receive care for covered services, and then your plan covers the rest.

What's an out-of-pocket limit?

Each year, there's a maximum amount you can pay out of your own pocket for covered services — that's your out-of-pocket limit. Once you've reached that limit — it varies by plan — we cover the rest for covered services. If you visit doctors or hospitals that aren't in your plan, you'll still have out-of-pocket costs. With some plans, you still have copays even after you reach your out-of-pocket limit.

What about the money for the plan that gets taken out of my paycheck?

That's what you pay for the plan. Think of it like a membership fee. It's separate from what you pay when you get care.



Using your health plan

It's easy to get started with your plan and make the best of your benefits.*



Choose a doctor in your plan

Avoid getting care from doctors outside of your plan; it will cost you more or your plan may not cover it at all. We've made it easy for you to find doctors in your plan. Visit **anthem.com** to look for a primary care doctor, hospitals, labs and other health care professionals in your plan.



Use your ID card

You'll be a member after you complete enrollment and your benefits begin. Then, you'll be able to use your ID card. Don't forget, it's always available and easy to use on the Engage Wellbeing mobile app. It's like your passport to care since you'll need to show it whenever you go to the doctor or pharmacy.



Register to use online tools and resources

Once your benefits begin and you access your ID card, download and register on the Engage Wellbeing mobile app to get personalized information about your wellness programs and health plan.

Use the self-service tools to:

- Access benefit information.
- Find a doctor and receive personalized reminders.
- Estimate your costs, before you step into the doctor's office.
- Check the price of a drug or refill a prescription.
- Get support managing your health conditions and tracking health goals.
- View your health account balance and claims.



Preventive care is covered at no extra cost

Preventive care from a doctor in your plan is covered at 100%. Getting these regular checkups, screenings and shots can help you stay healthy and catch problems early – when they're easier to treat. So, talk to your doctor about what preventive care you may need to protect your health.



Save emergency room visits for emergencies only

Knowing where to go for care saves you time and money. So if you have a real emergency, head straight to the ER or call 911. Otherwise, visit your regular doctor or an urgent care center for minor medical issues.



We're here for you

When you become a member, we make it easy for you to get your questions answered in the way that works best for you.

- **By phone:** Call the Member Services number on your mobile ID card.
- **Online:** Download the Engage Wellbeing mobile app to chat with a team member.



Done driving to the doctor? Hey there, Live Health Online!

You can visit a board-certified doctor 24/7 for simple things like the cold, flu, allergies and more with no appointments and no waiting room. All you need is the LiveHealth Online mobile app or a computer with a webcam to have a video visit with a doctor.** LiveHealth Online costs as little as an office visit or at most \$49. Learn more at livehealthonline.com.

* Limitations and exclusions are listed in the back of this book.

** Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to expand in the near future. Visit livehealthonline.com to view the service map by state.



Your pharmacy benefits

Here's an overview to help you enroll.*

Getting the medication you need is important for good health. Your plan will cover:

- Brand-name and generic drugs covered by your benefits. Your options include plans with different drug lists. Check your plan details to see which drug list the plan is using.
 - You can find out if the drug you take is included on the **National 4-tier** Drug List by visiting [anthem.com/VA/Nationaltier4](https://www.anthem.com/VA/Nationaltier4).
- Most specialty drugs if you have an ongoing health issue or serious illness.

Understand how your pharmacy benefits work

It's important to understand how your health plan works when you visit the pharmacy.

Your annual 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.

What you pay after meeting your deductible

After you meet your deductible, your plan will share the cost of medicine. Your options include plans with different ways of sharing the cost:

- **Copays:** 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.
- **Coinsurance:** You pay a certain percentage of the drug's cost, which can be different based on the pharmacy you use.

Once you're a member, you can check the price of a drug at different pharmacies on [anthem.com](https://www.anthem.com) and see if there are lower-cost drugs.

Save money with Tier 1 drugs

Drugs are listed in groups called "tiers." Your cost is based on which tier the drug is in. Lower-cost drugs and generics are usually in Tier 1 and 2. You can see from the chart that you'll save the most money when you use Tier 1 drugs. You'll pay more out of pocket for drugs in higher tiers.

	Drug type	Cost
	Preferred generic	\$
	Preferred brand name and newer, more expensive generic drugs	\$\$
	Non-preferred brand and generic drugs	\$\$\$
	Preferred specialty drugs (brand and generic)	\$\$\$\$

* Limitations and exclusions are listed in the back of this book.



Take advantage of your pharmacy benefits



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/rxnetworks.html](https://www.anthem.com/pharmacyinformation/rxnetworks.html) and choose the **National Plus** network list of pharmacies.



Use generics for health — and wealth. Talk to your doctor about using a generic versus a brand-name drug. Because generics cost less than brand-name drugs, they'll save you money.



Use over-the-counter drugs when possible. For some health issues, you may not need to see a doctor for relief. Over-the-counter drugs can treat common health problems like allergies or an upset stomach. They aren't covered by your health plan, but you could save time and money without having to see a doctor for a prescription and they usually cost less. Keep a list of your over-the-counter drugs to show your doctor at the next visit, so he or she can make sure there are no drug interactions that could harm you.

Specialty drugs are covered if you need them

Specialty drugs are for people with serious health issues. They come in different forms like pills or liquids. And some need to be injected, inhaled or infused. These drugs often need special storage and handling, and may be given to you by a doctor or nurse.

For more information about how your pharmacy benefits work, visit [anthem.com/faqs/virginia/pharmacy/](https://www.anthem.com/faqs/virginia/pharmacy/)





Health and wellness programs support you along the way

Your plan goes way beyond covering doctor visits

We can help you reach your health goals and save money on healthy products and services. After your benefits begin, you have easy access to these programs and tools on the Engage app or by calling the Member Services number on your mobile ID card.



Engage — This is your personalized health assistant that brings together all of your health care needs. Manage your benefits, track your health goals and monitor success with real-time reports all in one place. Just download the Engage WellBeing app to get started.



24/7 NurseLine — Our registered nurses can answer your health questions wherever you are — any time, day or night. All you have to do is call.



Case Management — If you're in the hospital or have a serious health problem and need extra care, a nurse care manager can help. Your nurse care manager will answer your questions, set up your care with different doctors and help you use your health benefits.



ConditionCare — Get support from a dedicated nurse team if you have asthma, diabetes, heart disease or heart failure. You work with dietitians, health educators and pharmacists to help you reach your goals and feel your best.



Enhanced Personal Health Care — This program supports you with main doctors, also called primary care doctors, who are real partners in your care. They get to know you and your history, and connect you to the specialists and services you need when you need them — even after hours.



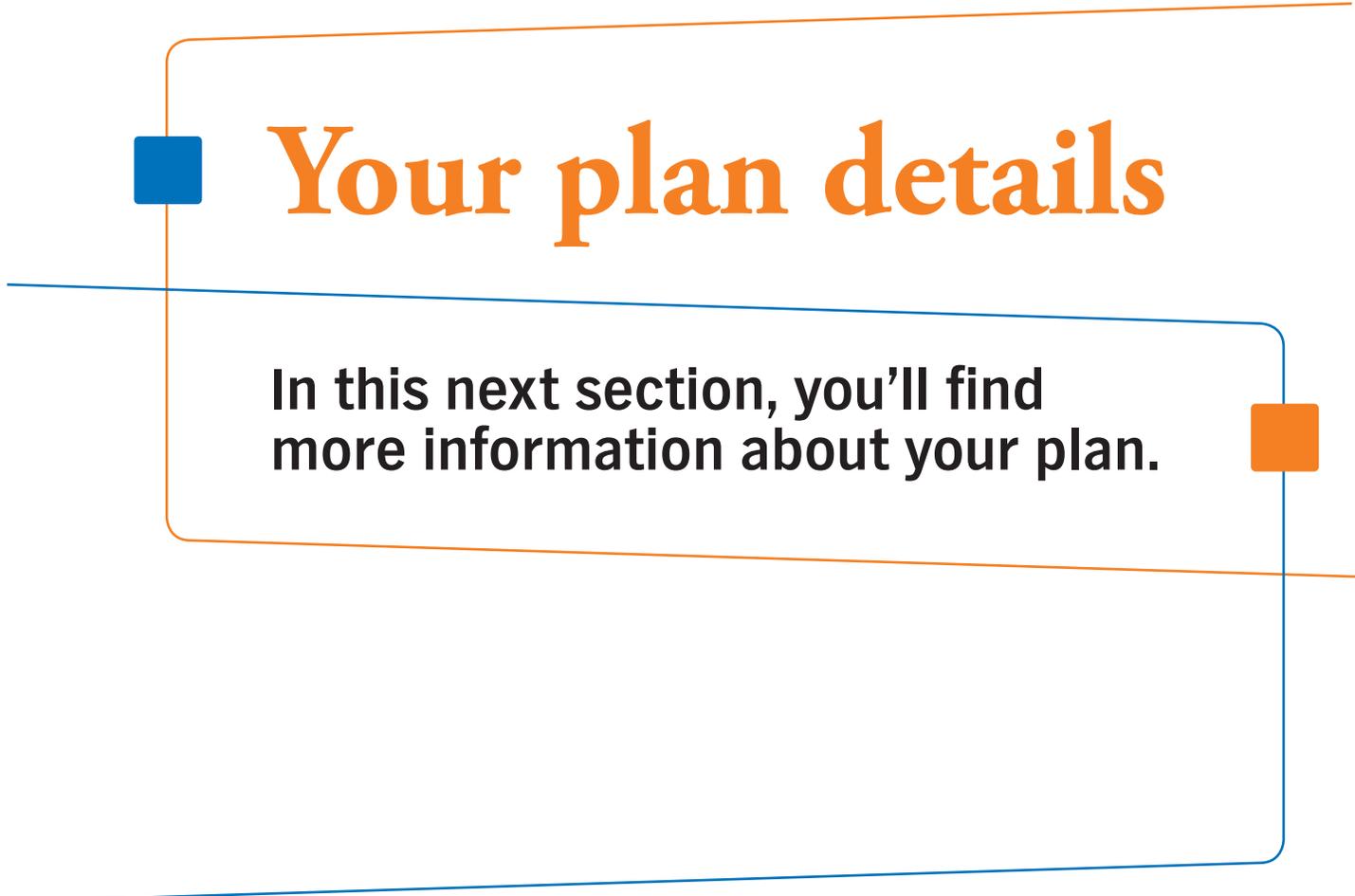
Future Moms — Moms-to-be get one-on-one support from registered nurses to help them have a healthy pregnancy, a safe delivery and a healthy baby. The program also includes breastfeeding support on LiveHealth Online. You can visit a lactation consultant, counselor or registered dietitian through private and secure video using your mobile device or computer.



Health Assessment — Once you're a member, you'll have access to a Health Assessment on [anthem.com](https://www.anthem.com). Answer a few questions and you'll get a health score with personalized tips on how to reach your healthy best.

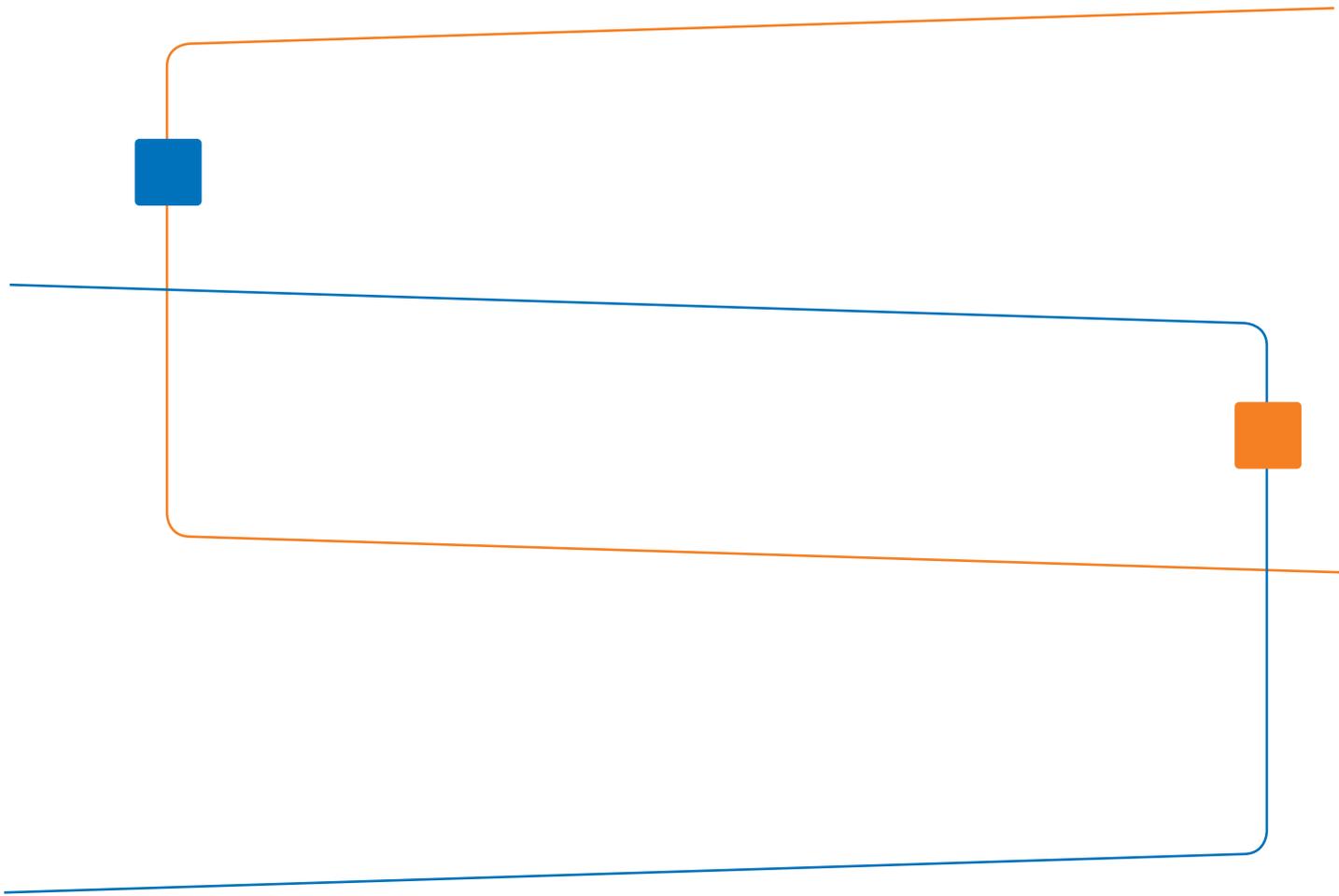


LiveHealth Online — Using LiveHealth Online, you can have a video visit with a board-certified doctor or therapist on your smartphone, tablet or computer with a webcam. It's easy to use and there when you need it. All you have to do is sign up at [livehealthonline.com](https://www.livehealthonline.com) or download the Engage Wellbeing app.



Your plan details

In this next section, you'll find more information about your plan. 





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:
<p>What is the overall Calendar Year deductible?</p>	<p>\$2,000/ member or \$4,000/family for In-Network Providers. 3,000/ member or \$6,000/family for Out-of-Network Providers.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. In-Network Preventive care and annual Vision exam for In-Network Providers.</p>	<p>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.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the Medical/Drug out-of-pocket limit for this plan?</p>	<p>\$5,000/ member or \$10,000/family for In-Network Providers. \$7,250/ member or \$14,500/family for Out-of-Network Providers.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Cost share of adult routine vision care, Premiums, Balanced-Billed charges, and Health Care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes, KeyCare. See www.anthem.com or call 1-833-592-9956 for a list of Network Providers.</p>	<p>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.</p>

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-----
If you have a test	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.
	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.express-scripts.com	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required
	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.
	Tier 2 - Typically Preferred/Brand	\$40/prescription (retail) and \$100/prescription (home delivery)	\$40/prescription (retail) (no home delivery)	Most Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply.
	Tier 3 - Typically Non-Preferred Brand	\$75/prescription (retail) and \$188/prescription (home delivery)	\$75/prescription (retail) (no home delivery)	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 Accredo. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 copay + 20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	No cost share	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	Prerecertification 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	Prerecertification required.
If you are pregnant	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	
	Home health care	\$30 copay/visit	40% coinsurance	100 visits/per calendar year.
If you need help recovering or have other special health needs	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	100 day per stay limit; pre-authorization required.
If your child needs dental or eye care	Skilled nursing care	20% coinsurance	40% coinsurance	-----none-----
	Durable medical equipment	20% coinsurance	40% coinsurance	-----none-----
	Hospice service	No cost share	40% coinsurance	-----none-----
	Children's eye exam	\$15/visit	\$30 allowance	One routine exam per calendar year
	Children's glasses	Not covered	Not covered	-----none-----
Children's dental check-up	Not covered	Not covered	-----none-----	

Excluded Services & Other Covered Services:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan document</u> .)	
Chiropractic care 30 visits/benefit period. Adult Routine Eye Exams Autism Spectrum Disorder	Coverage provided outside the United States. See www.bcbs.com/bluecardworldwide Private-duty nursing 16 hours/member/benefit period
	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. _____



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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
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 ለማግኘት (833) 592-9956 ይደውሉ።

(833)592-9956 اتصل على مترجم، للحدث إلى مترجم، للمعلومات بلغتك دون مقابل. (العربية) Arabic

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

Bassa (Básóó Wùdù): M̄ d̄yi d̄yi-diè-dè b̄é b̄édé b̄á céè-dè nià ke d̄yí ní, ɔ mò nì d̄yí-b̄édèin-d̄è b̄é ìn k̄é gbo-kpá-kpá k̄é b̄ǎ kp̄ǎ k̄é ìn b̄íqí-wùdùùn b̄ó pídyi. 'Bé ìn k̄é wudu-zìin-nyò d̄ò gbo wùdù ke, d̄á(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 အချက်အလက်များနှင့် 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 noŋ thiëec në ke de yā thoŋ, ke yin noŋ loŋ bē yi kuony ku wer alēu bē gēer yic yin ne thoŋ du ke cin wēu tāauē ke piny. Te kor yin ba jam wēnē ran ye thok geryic, ke yin col (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 (فارسی): در صورتی که سؤالی بپرسامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادرتان 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 διεγμνηά, τηλεφωνήστε στο (833)592-9956.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્ન નો પ્રિય 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 है, 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): O bụrụ na ị nwere ajuju o bụla gbasara akwukwu a, ị nwere ikike inweta enyemaka na ozi n'asụsụ ị na akwughị ugwo o bụla. Ka ị na okwu 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 tulog ken impormasyon babaen ti lengua hem 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 icyo 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. ເພື່ອໄວ້ລົມກັບລ່າມເປັນພາສາ, ໃຫ້ໂທຫາ (833)592-9956.

Navajo (Diné): Dii naaltsoos bika'igií lahgo bina'idilkidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehjī bee níl hodoomih t'áadoo bą́ąh ń́línigóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo koj'í' hodóólnih . (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 wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketim kaffaltii alla argachuuif mirgaa qabdaa. Turjumaana dubaachuuf, (833)592-9956 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwver selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833)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 num(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 ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਰੀਏ 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 ท่านมีสิทธิ์ที่จะได้ ได้รับความช่วยเหลือและขอ ้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย 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 مند اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لیے، (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

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

Yoruba (Yorùbá): Tí o bá ní èyíkẹyí ibèrè nípá àkọsilẹ yì, o ní ètọ́ láti gba àrànwọ́ àti iwífún ní èdè rẹ lófẹẹ. Bá wa ògbùfọ kan sọrọ, 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:
<p>What is the overall Calendar Year deductible?</p>	<p>\$0/member or \$0/family for In-Network Providers. \$500/member or \$1,000/family for Out-of-Network Providers.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. In-Network Preventive care and annual Vision exam for In-Network Providers.</p>	<p>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.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the Medical/Drug out-of-pocket limit for this plan?</p>	<p>\$5,000/ member or \$10,000/family for In-Network Providers. \$6,500/ member or \$13,000/family for Out-of-Network Providers.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Cost share of adult routine vision care, Premiums, Balanced-Billed charges, and Health Care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes, KeyCare. See www.anthem.com or call (833)592-9956 for a list of Network Providers.</p>	<p>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.</p>

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.
	Tier 2 - Typically Preferred/Brand	\$40/prescription (retail) and \$100/prescription (home delivery)	\$40/prescription (retail) (no home delivery)	Most Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply.
	Tier 3 - Typically Non-Preferred Brand	\$75/prescription (retail) and \$188/prescription (home delivery)	\$75/prescription (retail) (no home delivery)	In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay.
	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	Your plan uses a preferred drug list (formulary). Self-administered Specialty drugs must be dispensed by Accredo. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements.
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	
If your child needs dental or	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	Hearing aids	Routine foot care other than for Diabetes
Cosmetic surgery	Infertility treatment	Weight loss programs
Dental care	Long-term care	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.	Coverage provided outside the United States. See www.bcbs.com/bluecardworldwide	Routine eye care (adult)
Adult Routine Eye Exams		
Autism Spectrum Disorder	Private-duty nursing 16 hours/member/benefit period	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
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 ለማግኘት (833)592-9956 ይደውሉ።

. (833)592-9956 اتصل على مترجم، التحدث إلى مترجم. للمعلومات والمساعدات بلغتك دون مقابل. (العربية) Arabic

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

Bassa (Básóó Wùdù): M̄ d̄yi d̄yi-diè-dè b̄é b̄édé b̄á céè-dè nià ke d̄yí ní, ɔ mò nì d̄yí-b̄édèìn-d̄è b̄é ìn k̄é gbo-kpá-kpá k̄é b̄ǎ kp̄ǎ k̄é ìn b̄íqí-wùdùùn b̄ó pídyi. B̄é ìn k̄é wudu-zìin-nyò d̄ò gbo wùdù ke, d̄á (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 (ပြန်စာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် 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 noṅ thiēc nē ke de yā thoṛē, ke yin noṅ loṅ bē yi kuony ku wer alēu bē gēer yic yin ne thoṅ du ke cin wēu tāauē ke piny. Te kor yin ba jam wēnē ran ye thok geryic, ke yin col (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 (فارسی): در صورتی که سؤالی بپرسامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادرتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس 451-1527 (800) 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 διεγμνηά, τηλεφωνήστε στο (833)592-9956.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્ન નો પ્રિય 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 है, 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): O bụrụ na ị nwere ajuju ọ bụla gbasara akwukwọ a, ị nwere ikike inweta enyemaka na ozi n'asụsụ ị na akwughị ụgwọ ọ bụla. Ka ị 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 lengua hem 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 icyo 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. ເພື່ອໄດ້ຮັບກັບວ່າມາພາສາ, ໃຫ້ໂທຫາ (833)592-9956

Navajo (Diné): Dii naaltsoos bika'igií lahgo bina'idilkidgo ná bohóneédzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehjī bee níl hodoomih t'áadoo bą́ąh ílínigóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo koj'í' hodóólnih (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 wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketim kaffaltii alla argachuuif mirgaa qabdaa. Turjumaana dubaachuuf, (833)592-9956 bilbilla.

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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

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

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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 bilo 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 ท่านมีสิทธิ์ที่จะได้ ได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย 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 مند اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لیے، (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 אהר קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833)592-9956.

Yoruba (Yorùbá): Tí o bá ní èyíkẹyí ibèrè nípá àkọsilẹ yì, o ní ètọ́ láti gba àrànwọ́ àti iwífún ní èdè rẹ lófẹẹ. Bá wa ògbùfọ kan sọrọ, 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/IDD: 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/ff>. 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Preventive care/screening/immunization	No cost share	20% <u>coinsurance</u>	-----none-----
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab – Office 0% <u>coinsurance</u> X-Ray – Office 0% <u>coinsurance</u>	Lab – Office 20% <u>coinsurance</u> X-Ray – Office 20% <u>coinsurance</u>	Lab – Office -----none----- X-Ray – Office -----none-----
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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)	<i>Copays & Coinsurance apply after Deductible.</i> 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 Accredo specialty 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 <u>Specialty Drugs</u> (Self-Injectable only)	20% <u>coinsurance</u> up to \$200/prescription (retail and home delivery)	n/a	
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Physician/surgeon fee	0% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	Covered as In- <u>Network*</u>	-----none-----
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	Covered as In- <u>Network*</u>	-----none-----
	<u>Urgent care</u>	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g, hospital room)	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-auth required
	Physician/surgeon fees	0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----

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

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 Inpatient services Office visits Childbirth/delivery professional services Childbirth/delivery facility services	Office Visit	Office Visit	Office Visit -----none----- Other Outpatient -----none----- -----none-----
		0% coinsurance Other Outpatient	20% coinsurance Other Outpatient	
		0% coinsurance	20% coinsurance	
		0% coinsurance	20% coinsurance	
		0% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
		0% coinsurance	20% coinsurance	
If you are pregnant	Home health care Rehabilitation services Habilitation services Skilled nursing care Durable medical equipment Hospice services	0% coinsurance	20% coinsurance	100 visits/benefit period.
		0% coinsurance	20% coinsurance	Visit limits apply.
		0% coinsurance	20% coinsurance	
		0% coinsurance	20% coinsurance	100 day limit/stay.
		0% coinsurance	20% coinsurance	-----none-----
		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	Private Duty Nursing (limitations apply)	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/ft>.

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](#).

_____ *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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
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
<i>What isn't covered</i>	
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 በራሱዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833)592-9956 ይደውሉ።

(833) 592-9956 على اتصل مع مترجم، للتحدث إلى مترجم. للمساعدة والمعلومات بلغتك دون مقابل. (العربية) Arabic

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 (Bässò wùdù): M̄ dyi dyi-diè-dè bē bédé bá céè-dè nià ke dyí ní, ɔ mò ni dyí-bédèin-dè bē m̄ ké gbo-kpá-kpá kè bǝ kpǝ dé m̄ bídíj-wùdùùn bǝ pídyi. Bē m̄ ké wudu-ziin-nyò dǝ gbo wùdù ke, dǝ (833) 592-9956.

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

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ မေးစရာမလိုပဲ 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 naṅ thiëc nē ke de yā thoṛē, ke yin naṅ loṅ bē yi kuony ku wer alēu bē gēer yic yin ne thoṅ du ke cin wēu tāāuē ke piny. Te kor yin ba jam wēnē ran ye thok geryic, ke yin col (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 (فارسی): در صورتی که سؤالی بپرسید، این حق را دارید، این سند را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادرتان دریافت کنید. برای گفتگو با یک مترجم شما، 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 διεγμηνέα, τηλεφωνήστε στο (833)592-9956.

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

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

Hindi (हिंदी): अगर आपके पास इस दस्तावेज 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): O bur u na i nwere ajiuju o buła gbasara akwuukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwuighi ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (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 lengluehem 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 អ្នកមានសិទ្ធិទទួលបាននូវឯកសារសំណួររបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជ្រើសរើសភាសាអ្នកបកប្រែ 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 ຂໍ້ມູນເປັນພາສາຂອງທ່ານໃດໆບໍ່ເສຍຄ່າ. ເພື່ອໄດ້ຮັບກັບລ່າມເປັນພາສາ, ໃຫ້ໂທຫາ (833)592-9956

Navajo (Diné): Dít naaltsoos biká'ígíí lahgo bina'í díłkígdgo ná bohónéédzá dóó bee ahóót'í t'áá ní nizaad k'ehjí bee nít hodoonih t'áadoo bááh ílínígóó. Ata' hainé'ígíí la' bich'i'í hadeesdzih ninizingo kojí' hodiilnih (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 wajjin 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 (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schpbrooch mitaus Koscht. Um mit en Iwvresetze zu schwetze, ruff (833)592-9956 aa.

Polish (polski): W przypadku jakichkolwiek pytań/wiązań/tych niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać 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 ਮੁਫਤ 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 (Samoan): 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 auoa ma se tofogi. 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 tagapagpaliwagan, 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..

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 דא רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך און פריי. צו רעדן צו אן איבערזעצער, רופט (833) 592-9956.

Yoruba (Yorùbá): Tí o bá ní èyúkẹyí ibèrè nípá akosilẹ̀ yí, o ní ètọ́ láti gba iranwo àti iwífún ní èdè rẹ̀ ló fẹ́. 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>.

Anthem Medical Plans effective January 1, 2019

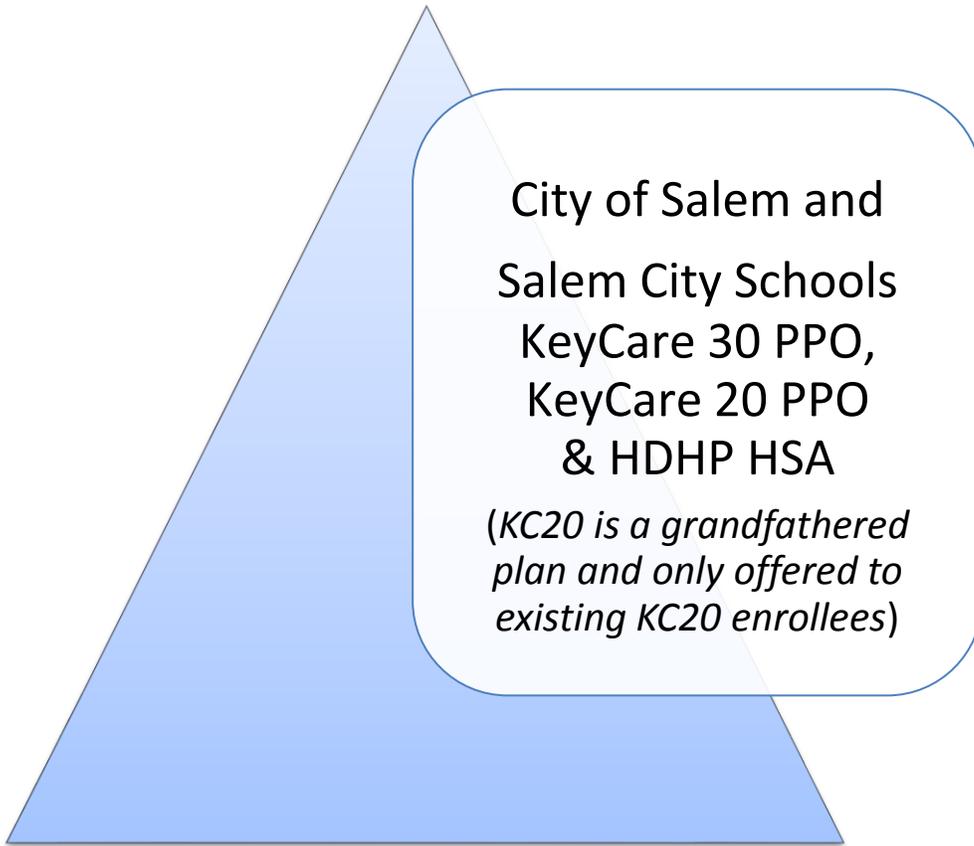
- Keycare 30 PPO with \$15/\$40/\$75/20% drug plan
- HDHP HSA with \$10/\$30/\$50/20%, after deductible drug plan
- Keycare 20 PPO with \$15/\$40/\$75/20% drug plan (KC20 is a grandfathered plan and only offered to existing KC 20 enrollees)

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, 2019

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 <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	No cost share
Routine Vision	
<ul style="list-style-type: none"> annual routine eye exam <i>Plus valuable discounts on eyewear</i>	\$15 for each visit
Doctor Visits	
<ul style="list-style-type: none"> office visits urgent care visits online visits (https://livehealthonline.com) (does not include livehealthonline mental health/substance abuse therapist visits) mental health and substance abuse office visit (including livehealthonline therapist visits) spinal manipulation and other manual medical intervention visits (30 visit limit) 	<ul style="list-style-type: none"> pre- and postnatal office visits* home visits \$30 for each visit to a PCP \$50 for each visit to a specialist
All Other In-Network Services	
<p>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.</p> <ul style="list-style-type: none"> 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). 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. <p>Once you reach your deductible you pay:</p>	
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
<ul style="list-style-type: none"> diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> behavioral health treatment* psychiatric care therapeutic care** <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
<ul style="list-style-type: none"> shots and therapeutic injections medical appliances, supplies and medications, including infusion medications durable medical equipment diagnostic lab services in-office surgery chemotherapy (not given orally), IV, radiation, cardiac and respiratory therapy <p>*Limit does not apply to Autism Spectrum Disorder.</p>	<ul style="list-style-type: none"> physical and occupational therapy visits in an office setting (30 combined visits)* speech therapy visits in an office setting (30 visit limit)* dialysis diagnostic x-rays ambulance travel 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	
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
Outpatient Services in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* ○ partial day mental health and substance abuse services ○ emergency room ○ surgery <p><i>*Limit does not apply to Autism Spectrum Disorder.</i></p>	20% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> ○ home health care (100 visits) ○ private duty nursing limited to 16 hours per member per calendar year <p><i>*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.</i></p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ hospice care 	No cost share
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services. ○ 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	
<p>It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$3,000 in one calendar year. This is called your out-of-network deductible.</p> <ul style="list-style-type: none"> ○ 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). ○ 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. <p>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.</p>	
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 <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	*No cost share
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <p style="margin-left: 20px;"><i>Plus valuable discounts on eyewear</i></p>	\$15 for each visit
Doctor Visits	
<ul style="list-style-type: none"> <li style="width: 50%;">○ office visits <li style="width: 50%;">○ spinal manipulations and other manual medical intervention visits (30 visit limit) <li style="width: 50%;">○ urgent care visits <li style="width: 50%;">○ in office surgery <li style="width: 50%;">○ home visits 	\$30 for each visit to a PCP \$50 for each visit to a specialist
<ul style="list-style-type: none"> ○ 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	
<ul style="list-style-type: none"> ○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> <li style="width: 50%;">○ behavioral health treatment* <li style="width: 50%;">○ pharmacy care <li style="width: 50%;">○ psychiatric care <li style="width: 50%;">○ psychological care <li style="width: 50%;">○ therapeutic care** <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ 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	
<ul style="list-style-type: none"> ○ 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	
<ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays ○ dialysis ○ infusion services ○ shots and therapeutic injections, including infusion medications ○ 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
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ durable medical equipment 	20% of the amount the health care professionals in our network have agreed to accept for their services.
<ul style="list-style-type: none"> ○ 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	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* <p><i>*Limit does not apply to Early Intervention and Autism Spectrum Disorder.</i></p>	<p>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.</p>
<ul style="list-style-type: none"> ○ surgery <p><i>*For the services billed by the doctor, you will pay an additional \$30 or \$50 depending on the type of doctor who treats you.</i></p>	<p>\$200 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	<p>Member cost shares will be dependent on the services rendered.</p>
Emergency Care	
<ul style="list-style-type: none"> ○ emergency room 	<p>\$200 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ emergency room physician services 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Mental Health and Substance Abuse Outpatient Services	
<ul style="list-style-type: none"> ○ office visits 	<p>\$30 for each visit</p>
<ul style="list-style-type: none"> ○ outpatient facility (including partial day mental health and substance abuse services) ○ outpatient facility professional provider services 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Care at Home	
<ul style="list-style-type: none"> ○ hospice care 	<p>No cost share</p>
<ul style="list-style-type: none"> ○ home health care (100 visits) ○ private duty nursing limited to 16 hours per member per calendar year* <p><i>*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 charges.</i></p>	<p>\$30 copay per visit</p> <p>20% of the amount the health care professionals in our network have agreed to accept for their services.</p>
Maternity	
<ul style="list-style-type: none"> ○ all routine pre- and postnatal care (excluding inpatient stays) 	<p>\$200 per pregnancy</p>
<ul style="list-style-type: none"> ○ diagnostic test ○ non-stress tests and other fetal monitor procedures ○ ultrasounds 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit <p><i>*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.</i></p>	<p>\$300 plus 20% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>

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 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.

Your prescription drug plan (continued)

Specialty Pharmacy

Accredo, the Express Scripts 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

Accredo CareLogic® programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication and side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. 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. Call 800-870-6419 to learn about how CareLogic can help you better manage your health condition.

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 "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the Drug List on this page. 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 choose 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.

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.

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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 <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	No cost share*	
Routine Vision		
<ul style="list-style-type: none"> ○ annual routine eye exam <i>Plus – valuable discounts on eyewear</i> <p>If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$3,000 deductible) and you will pay the rest of what the professional charges.</p>	\$15 for each visit	
Annual Deductible		
<p>Your deductible is combined for In-network and Out-of-Network services.</p> <ul style="list-style-type: none"> ○ For single coverage, you will pay all the costs associated with your care until you have paid \$3,000 in one calendar year. ○ 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). ○ 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. <p>In-Network Services Once you have reached this amount, you will pay the amounts designated in the “you pay” column below.</p> <p>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.</p>		
Once you reach your deductible, you will pay the following for covered in-network services		
All Other In-Network Services	You Pay	
Doctor Visits		
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits ○ mental health and substance use visits ○ in-office surgery <p>* Limit does not apply to Autism Spectrum Disorder.</p>	<ul style="list-style-type: none"> ○ physical and occupational therapy in an office setting (90 combined visits)* ○ speech therapy visits in an office setting (90 visit limit)* ○ spinal manipulations and other manual medical intervention visits (30 visit limit) 	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		
<ul style="list-style-type: none"> ○ diagnostic lab services ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy 	<ul style="list-style-type: none"> ○ diagnostic x-rays ○ dialysis ○ ambulance travel ○ durable medical equipment 	0% of the amount the health care professionals in our network have agreed to accept for their services

In-Network Services	You Pay
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> o diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> o behavioral health treatment* o pharmacy care o psychiatric care o psychological care o therapeutic care** <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> o applied behavioral analysis <ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> 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 <p>* Limit does not apply to Autism Spectrum Disorder.</p>	0% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> o private duty nursing is limited to 16 hours per member per calendar year* <p>*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.</p>	0% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> o Up to a 30-day medication supply at participating pharmacies <p><i>Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.</i></p>	After Deductible Tier 1 \$10 Tier 2 \$30 Tier 3 \$50 Tier 4 20% up to \$200/script
Home Delivery	
<ul style="list-style-type: none"> o Up to a 90-day medication supply delivered to your home <p><i>Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.</i></p>	After Deductible Tier 1 \$25 Tier 2 \$75 Tier 3 \$125 Tier 4 N/A
Retail Maintenance	
<ul style="list-style-type: none"> o Up to a 90-day medication supply at participating pharmacies 	After Deductible 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.

- If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).
- 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.

- If two people are covered under your plan, each of you will pay \$6,000 (\$12,000 total).
- 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:

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

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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

Accredo, the Express Scripts 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)

Accredo CareLogic® programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication and side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. 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. Call 800-870-6419 to learn about how CareLogic can help you better manage your health condition.

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 "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the Drug List on this page. 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 choose 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)

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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	<ul style="list-style-type: none"> At member's option can be performed at time of eye exam 	Not more than \$39
Eyeglass Frame	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses* 	35% off retail price
Eyeglass Lenses Standard plastic material	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses*: <ul style="list-style-type: none"> Single Vision \$50 Bifocal \$70 Trifocal \$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.	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses*: <ul style="list-style-type: none"> UV Coating \$15 Tint (Solid and Gradient) \$15 Standard Scratch-Resistant Coating \$15 Standard Polycarbonate \$40 Standard Anti-Reflective Coating \$45 Standard Progressive Lenses (add-on to Bifocal) \$65 Other Add-Ons 20% off retail price 	
Conventional Contact Lenses (non-disposable type)	<ul style="list-style-type: none"> 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:



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.

Take care of yourself

Use your preventive care benefits



And Its Affiliate HealthKeepers, Inc.

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

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

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

Preventive vs. diagnostic care

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

Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening*
- Eye chart test for vision²
- Hearing screening
- Height, weight and body mass index (BMI)
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years³
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

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

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met⁴
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling^{5,6,7}
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening⁶
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression⁶
- Pelvic exam and Pap test, including screening for cervical cancer

These preventive care services are recommendations of the Affordable Care Act (ACA or health care reform law). They may not be right for every person, so ask your doctor what's right for you.

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

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

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and BMI
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24 with fair skin about lowering their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening when done as part of a preventive care visit²

Immunizations:

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

¹ The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

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

³ You may be required to get preapproval for these services.

⁴ Check your medical policy for details.

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

⁶ This benefit also applies to those younger than age 19.

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

The savvy member's action guide

Smart ways Anthem members get more from their health plans

Sometimes the simple things make a big difference

Here are a few easy tips you can use to get more from your benefits and save money on health care. You can find more detailed information on these tips at anthem.com.

Savvy ways to keep overall costs down

Tip #1: Ask about your choices for certain kinds of care

Hospitals have higher overhead costs, so they usually charge more for their inpatient and outpatient care. Many services can be performed in a doctor's office, surgery center or freestanding radiology center. This saves you out-of-pocket costs. You usually only pay your copay (a set amount of your share of the costs) instead of coinsurance (a percentage of the costs) for care you get in a doctor's office or freestanding center.

It's also important to know that not all providers within a contracted hospital may be individually contracted to provide care to our members. For example, if you are scheduled for a procedure that would involve the services of several providers, such as an anesthesiologist or a radiologist, it's possible that not all of the providers helping to render your care are contracted providers within our network. If that occurs, nonparticipating providers can charge you for costs above and beyond what we have agreed to pay for covered services with providers who are in our network.

So it's important to find out up front if all of the hospital-based providers who will be serving you are part of our network. There are several ways you can check to make sure a hospital-based provider is also part of our network:

- Ask for a complete list of all providers who will be providing services.
- Ask the facility if each provider is a contracted provider within our network.
- Call Member Services to confirm if the provider is in our network.
- Log on to anthem.com and use the **Find a Doctor** tool to look up the provider and verify if the provider is in our network.
- If your admission to a hospital is unplanned and therefore considered an emergency, there may not be time to determine up front if providers treating you are in our network. If possible, a family member may be able to check on your behalf.

Tip #2: Estimate your Cost

Did you know that different hospitals and facilities charge different amounts for the same services? Now you can know your cost before you set foot in the hospital. By getting an estimate of your costs based on the benefits of your health plan, you can choose a facility that fits your budget.

How to get an estimate of costs:

- Log in at anthem.com and select **Estimate Your Cost**.
- Simply search or browse for the procedure you are looking for and the tool will help guide you.
- You can easily compare facilities in your area.

Tip #3: Keep an eye on your EOB

You'll receive an *Explanation of Benefits* (EOB) whenever you get care. It's like your personal claim and coverage report. When you get one, make sure it's right and only lists care you received. If you're ever unsure about a charge, call the Member Services number on your Anthem ID card and we'll help clear things up.

Tip #4: Use network doctors and hospitals

You have access to some of the largest networks of doctors. That means the doctors you already know and trust are likely in our networks. We work with our large provider networks to make sure when you visit a network doctor, your share of the cost is lower — even before you pay any deductible — so you can save from day one of your coverage. You also get access to providers across the country. When you get care out of the network, you'll pay more and you'll likely have to file claims yourself (network doctors do that for you).

Three quick ways to find network care:

1. Type anthem.com into your smartphone browser to use our easy mobile app.
2. Log in to anthem.com and select **Find a Doctor**.
3. Call the Member Services number on your Anthem ID card.

Savvy places to get quality care at lower costs

Tip #1: Get live access to doctors 24/7 with your computer or phone through LiveHealth Online

LiveHealth Online is a new benefit that allows you to speak directly to doctors 24 hours a day for the cost of an office visit copay. Visit livehealthonline.com to register.

Tip #2: Ask about your options for radiology services

We give your doctor quality and cost information for radiology centers in your area. This list can help you get the highest quality care at the lowest cost. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. (Anthem) include in-network radiology centers that have been rated on many factors, including quality and cost. You and your doctor can use this list together to help you choose the right radiology center for you.

Tip #3: Use freestanding labs

You can usually visit a freestanding lab for things like blood and urine tests. This is another way you can lower your out-of-pocket costs.

Tip #4: Use urgent care or walk-in centers when it's not life-threatening

Emergency room (ER) care costs a lot more money and time than care you get in your doctor's office, urgent care or walk-in centers. So save the ER for true emergencies. For things like minor cuts and sprains, ear or throat infections, bronchitis and other non-life-threatening issues, you'll usually get care faster — and pay lower copays and/or coinsurance — when you use your network doctor's office, urgent care or walk-in center.





Savvy choices in preventive care and wellness programs

Tip #1: Get preventive care

You have 100% coverage for network checkups, flu shots and some cancer screenings like mammograms. Getting preventive care can help prevent childhood diseases, diabetes, high blood pressure, cancer and other health issues that could cost you a lot more in the long run. Get peace of mind and better health at no extra cost to you!

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

Your coverage includes access to preventive care services at no cost, which can really help you stay on track with your health. But it's important to understand the difference between preventive care and diagnostic care so there will be no surprises about out-of-pocket costs. If you see your doctor for a routine screening, such as a checkup, and there are no health issues discovered, that will be billed as a preventive care service. But if the doctor uncovers something that warrants more testing or treatment, it will be billed as a diagnostic visit and you will be expected to pay your regular cost share for an office visit copay. Also, if you have previously been diagnosed with a condition such as high cholesterol or diabetes and visit your doctor for a subsequent checkup, that visit will also be considered diagnostic rather than preventive and the applicable cost share will apply.

Tip #3: Take advantage of health and wellness programs at no extra cost

Let us help you live healthier, feel better and save money. Get help with an ongoing health problem, call our 24/7 NurseLine, or have a coach help you get fit, lose weight or quit smoking. It's all part of your plan at no extra cost. Not sure where to start? Take the Health Assessment at anthem.com. It looks at where you are now and the steps you can take to be your healthiest.

Looking for a doctor?

Finding one online is fast and easy

Use our online Find a Doctor tool to look for doctors, hospitals, pharmacies, labs and other health care providers in your Anthem network. Check if your favorite doctor is in the network, or look for one near you. Avoid getting out-of-network care if you can – it will cost you more or your plan may not cover it all.



Here's all you need to do:

If you're a member

Go to anthem.com and log in.

Or use your ID number or the first three letters to search without logging in.

Under *Useful Tools* on the right, select **Find a Doctor**.

1

If you're not a member yet

Go to anthem.com.

Under *Useful Tools* on the right, select **Find a Doctor**.



Next, select a type of provider, place or name. Select **Search**.

2

First answer a few questions, so we can help find you the right plan and in-network doctor. Then enter or select the plan/network*.

Next, select a type of provider, place or name. Select **Search**.

3

Select a provider to see more information, such as:

- Training
- Specialties
- Languages spoken
- Address (including a map)
- Phone number



Going mobile

Use your mobile device to search for doctors, hospitals and more with our free app from the App StoreSM or Google PlayTM. Just search for Anthem Blue Cross and Blue Shield and download the app. You can even get turn-by-turn directions to find a doctor's office.

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

LiveHealth Online Saves You Time – and Can Now Also Save You Money. (for groups with 51+ employees)



LiveHealth Online

Easy, fast doctor visits. All from the comfort of your own computer or mobile device.

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.* The program is available 365 days a year, 24 hours a day, seven days a week (including holidays) anywhere you have an internet connection.

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Private, secure and convenient online visits.
- Help at a cost that is same as your office visit copay or \$49 per visit, subject to deductible and coinsurance, depending on your health plan benefits.

New! LiveHealth Online can save you money

And, new for 2017, LiveHealth Online has gotten better because we're now reducing member cost shares for several of our plans when members use a LiveHealth Online provider instead of visiting their PCP. Members enrolled in a health care plan that requires at least a \$15 copay for visiting their PCP will now pay less when alternatively seeking care from LiveHealth Online. Of course, it's important that members make the health care decisions that are right at the time and for their particular situation. LiveHealth Online just gives you one more option.

Common treatments include:

- Cold/fever/flu
- Allergies
- Pink eye
- Sinus pain
- Sore throat
- Headache
- Vomiting
- Diarrhea
- Bronchitis
- Cold Sores
- Minor rashes
- Hives
- Trouble sleeping
- Ear pain

You will need your ID number from your ID card when creating your account in order for Anthem to identify you as a Plan participant.

LiveHealth Online is not intended for medical emergencies. If you experience an emergency, always call 911.



And Its Affiliate HealthKeepers, Inc.

*As legally permitted in certain states.

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

To access this program:

1. Log on to LiveHealthOnline.com.
2. Click **Sign Up** in the top right corner of the screen.
3. Complete the form to create your account and click **Finish**.
4. Review the physician profiles to select the one that's right for you and begin your consultation.

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. They even include toll-free access to a nurse any time, any day.

Condition Care

If you have a long-term health problem, ConditionCare is for you. It's a program that helps people with asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, coronary artery disease (CAD) and more. When you join the program, we'll give you the tools and resources you need to take charge of your health. You'll also get:

- 24/7 phone access to a nurse care manager who can answer your questions and give you up-to-date information about your condition.
- A health review and follow-up calls if you need them.
- Tips on prevention and lifestyle choices to help you improve your quality of life.

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:

- 24/7 phone access to a nurse coach you can talk to about your pregnancy and your health. A nurse may also call you from time to time to see how you're doing.

- A book that shows changes you can expect for you and your baby over the next nine months.
- Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks. You'll also get tips and resources to help you make better decisions and prepare for the birth of your baby.

24/7 NurseLine

You can call any time to talk to a registered nurse about your health concerns. You can get answers to questions, whether you're sick or not.

Need health care right away? A nurse can help you decide where to go if your doctor isn't available. Going to the right place can save you time and money. And you can access better care, too.

Get the support you need

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

- **ConditionCare:** 800-445-7922
- **Future Moms:** 800-828-5891
- **24/7 NurseLine:** 800-337-4770



And Its Affiliate HealthKeepers, Inc.

Health and wellness programs are not covered services under the health plan, but are additions; these programs' features are not guaranteed under your health plan certificate and could be discontinued at any time. 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 affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross 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.



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

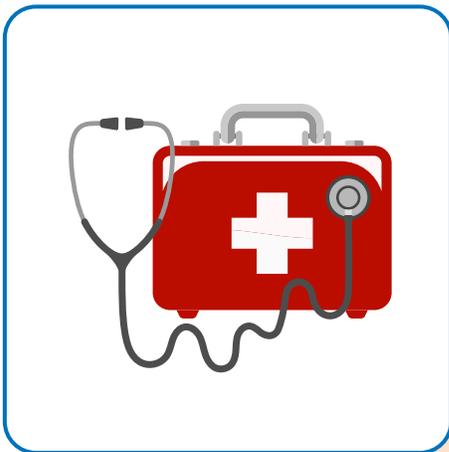
Who can be enrolled

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 calendar 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: <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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).
	●		<ul style="list-style-type: none"> 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
●		<ul style="list-style-type: none"> 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.
	●	<ul style="list-style-type: none"> 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.



The ins and outs of coverage

(continued)

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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



The ins and outs of coverage

(continued)

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



The ins and outs of coverage

(continued)

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



The following services and supplies will not be covered under your plan.

The ins and outs of coverage

(continued)

What's not covered (exclusions)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them. But, in order for us to keep the cost of health care coverage as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered in any case.

Acupuncture

Authorization in advance

Your coverage does not include benefits for those selected services that require authorization in advance, when the advance authorization is not obtained.

Applied behavior treatment

Includes, but is not limited to, applied behavior analysis and intensive behavior interventions for all indications unless otherwise covered as law.

Biofeedback therapy

Over-the-counter convenience and hygienic items including, but not limited to, adhesive removers, cleansers, underpads and ice bags.

Certain prescription drugs

If you could use a **clinically equivalent drug**, unless required by law, certain prescription drugs aren't covered. "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 drug is considered as clinically equivalent, visit our website at anthem.com. If you or your doctor believe you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us.

We'll cover the other prescription drug instead of the clinically equivalent drug only if we agree that it's medically necessary and appropriate. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

Convenience items

Your coverage does not include benefits for over-the-counter convenience and hygienic items. This includes but is not limited to: adhesive removers, cleansers, underpads, diapers, and ice bags.

Complications

Your coverage does not include benefits for complications of or services related to noncovered services including services, supplies or treatment related to, or for problems directly related to, a service that's not covered by this plan.

Directly related means that the care took place as a direct result of the noncovered service and would not have taken place without the noncovered service.

Cosmetic services

Your coverage does not include benefits for, or related to **cosmetic services**, including treatments, services, prescription drugs, equipment or supplies given for cosmetic purposes. Cosmetic services are meant to preserve, change or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This exclusion does not apply to surgery or procedures:

- To correct a deformity caused by disease, trauma or previous therapeutic process
- To correct congenital deformities that cause functional impairment
- On newborn children to correct congenital abnormalities



The ins and outs of coverage

(continued)

Delivery charges for delivering prescription drugs.

Dental or oral surgery services

Your coverage does not include benefits for the following **dental or oral surgery services**:

- Shortening or lengthening of the mandible or maxillae for cosmetic purposes.
- Surgical correction of malocclusion or mandibular retrognathia unless this condition creates significant functional impairment that cannot be corrected with orthodontic services.
- Dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia.
- Medications to treat periodontal disease.
- Treatment of natural teeth due to diseases.
- Biting and chewing-related injuries, unless the chewing or biting results from a medical or mental condition.
- Restorative services and supplies necessary to promptly repair, remove or replace sound natural teeth.
- Anesthesia and hospitalization for dental procedures and services except as specified as otherwise being covered.

This exclusion will not apply if your group's coverage includes a dental rider.

Drugs

Your coverage does not include drugs administered by a medical provider in the following circumstances:

- Drugs given to you or prescribed in a way that is against medical and professional standards of practice.
- Drugs which are over any quantity or age limits set by your coverage or by Anthem.
- Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription order.
- Drugs which are prescribed by a provider who does not have the necessary qualifications, registrations and/or certifications, as determined by us.
- 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.

Donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child or sibling).

Educational, vocational or self-management training purposes, except as otherwise specified as being covered or when received as part of covered preventive care.

Experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer.



The ins and outs of coverage

(continued)

Family planning

- Artificial insemination services, in-vitro fertilization or any other types of artificial or surgical means of conception, including drugs administered in connection with these procedures.
- Drugs used to treat infertility.
- Nonprescription contraceptive devices.
- Any services or supplies provided to a person not covered that is in connection with a surrogate pregnancy, including, but not limited to, the bearing of a child by another woman for an infertile couple.
- Services to reverse voluntarily induced sterility.

Foot care

Services for palliative (to relieve pain and other symptoms) or cosmetic foot care:

- Flat foot conditions
- Support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes
- Subluxations of the foot
- Corns, calluses and care of toenails (except in treatment for patients with diabetes or vascular disease)
- Bunions (except capsular or bone surgery)
- Fallen arches, weak feet or chronic foot strain
- Symptomatic complaints of the feet

Gene therapy as well as any drugs, procedures or health care services related to it that introduce or are related to introducing genetic material into a person intended to replace or correct faulty or missing genetic material.

Gynecomastia

Services for surgical treatments of gynecomastia for cosmetic purposes.

Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Hearing aids or exams to prescribe or fit hearing aids, unless otherwise listed as covered. This exclusion does not apply to cochlear implants.

Home care services:

- Homemaker services (except as rendered as part of hospice care)
- Maintenance therapy
- Food and home-delivered meals
- Custodial care and services

Hospital services:

- Guest meals, telephones, televisions and any other convenience items received as part of your inpatient stay
- Care by interns, residents, house doctors or other facility employees that are billed separately from the facility
- A private room, unless it is medically necessary and approved by us

Immunizations required for travel or work, unless such services are received as part of the covered preventive care services.

Lost or stolen drugs. Refills of lost or stolen drugs.



The ins and outs of coverage

(continued)

Medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use.

These include but are not limited to:

- Exercise equipment; air conditioners, dehumidifiers, humidifiers and purifiers; hypoallergenic bed linens, bed boards; whirlpool baths; handrails, ramps, elevators and stair glides; telephones; adjustments made to a vehicle; foot orthotics; and changes made to a home or place of business.
- Replacement or repair of purchased or rental equipment because of misuse, abuse or loss or theft.
- Surgical supports, corsets or articles of clothing unless needed to recover from surgery or injury.
- Nonmedically necessary enhancements to standard equipment and devices.
- Supplies, equipment and appliances that include comfort, luxury or convenience items or features that exceed what is medically necessary in your situation. Reimbursement will be based on the maximum allowed amount for a standard item that is a covered service, serves the same purpose and is medically necessary. Any expense that exceeds the maximum allowed amount for the standard item which is a covered service is your responsibility.

Medical equipment (durable) that is not appropriate for use in the home.

Services or supplies deemed not medically necessary as determined by us at our sole discretion. Except for this exclusion, all preventive care services and hospice care services described in the post-enrollment *Evidence of Coverage* or *Member Booklet* are covered.

This exclusion does not apply to services you receive on any day of inpatient care that we determined to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient. This includes pathologists, radiologists, anesthesiologists or consulting doctors.

Also, this exclusion does not apply to inpatient services you receive from your admitting or attending doctor, other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic or therapeutic services provided by your admitting or attending physician.

Also, this exclusion does not apply to the services you receive from pathologists, radiologists or anesthesiologists in an:

- Outpatient hospital setting
- Emergency room
- Ambulatory surgery setting

This exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent you from being able to appeal our decision that a service is not medically necessary.



Is a treatment considered experimental?

Many of our medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage.

To be approved for coverage, the service or product must have:

- Regulatory approval from the Food and Drug Administration.
- Been put through an extensive research study to find all the benefits and possible harms of the technology.
- Benefits that are far better than any potential risks.
- At least the same or better effectiveness as any similar service or procedure already available.
- Been tested enough so that we can be certain it will result in positive results when used in real cases.



The ins and outs of coverage

(continued)

Non-emergency care except for the initial screening and stabilization of the patient. This includes but is not limited to suture removal in the emergency room.

Nutrition counseling and related services, except when provided as part of diabetes education, mental health treatment of an eating disorder or when received as part of a covered preventive care services visit or screening.

Nutritional and/or dietary supplements, except as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Obesity services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Except for provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies and lipectomies), are not covered services even though the services may be required to correct a deformity after a previous therapeutic process involving gastric bypass surgery.

Off-label use, unless we must cover it by law or as we approve it.

Organ or tissue transplants, including complications caused by them, except as outlined in the *What is Covered* section of the post-enrollment *Evidence of Coverage* or *Member Booklet*.

Paternity testing, your coverage does not provide any benefits for paternity testing.

Prescription drugs received from a retail or home delivery (mail order) pharmacy

This exclusion does not apply to prescription medications for palliative care and pain management provided as part of hospice care services.

Your coverage does not include benefits for **private duty** nurses in an inpatient setting (applies to Anthem KeyCare and Lumenos plans).

Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center.

This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house or school because a member's own home arrangements are not available or are unsuitable and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled or outward bound programs, even if psychotherapy is included.
- Wilderness camps.

Rest cures, custodial, residential or domiciliary care and services

Whether care is considered residential will be determined based on factors such as if you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments and structured therapeutic service.



The ins and outs of coverage

(continued)

Routine physicals

Your coverage does not include benefits for routine physicals 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 preventive care benefits.

Services or supplies or devices:

- Not listed as covered under your health plan.
- Not prescribed, performed or directed by a provider licensed to do so.
- Received before the effective date or after a covered person's coverage ends.
- Received by providers not licensed by law to provide covered services. Examples include masseurs or masseuses (massage therapists), physical therapy technicians and athletic trainers.
- Services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.
- Benefits for charges from stand-by physicians in the absence of covered services being rendered.
- Telephone consultations, charges for not keeping appointments or charges for completing claim forms.

Services or supplies if provided or available to a member:

- Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payer after benefits under this plan have been paid.
- Provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government.

- This exclusion applies whether or not the member waives his or her rights under these laws, amendments, programs or terms of employment. However, we will provide the covered services specified in the post-enrollment *Evidence of Coverage* or *Member Booklet* when benefits under these programs have been exhausted.

Services for which a charge is not usually made including those services for which you would not have been charged if you did not have health care coverage services or benefits for:

- Amounts above the allowable charge for a service.
- Neurofeedback and related diagnostic tests.
- Penile implants.

Services or supplies to treat sexual dysfunction (male or female sexual problems). This includes medical and mental health services.

Skilled nursing facility stays:

- Treatment of psychiatric conditions and senile deterioration
- Facility services during a temporary leave of absence from the facility
- A private room unless it is medically necessary

Smoking cessation programs not affiliated with us.

Spinal manipulation

Your coverage does not include benefits for **spinal manipulation** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

Telemedicine

Noninteractive telemedicine services, including audio-only telephone, email messages, fax transmissions or online questionnaires.



The ins and outs of coverage

(continued)

Therapies:

- Physical therapy, occupational therapy or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- Group speech therapy
- Group or individual exercise classes or personal training sessions
- Recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling and nature therapy

Veins

Services for treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Vision services:

- Vision services or supplies, unless needed due to eye surgery and accidental injury.
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure.
- Services for vision training and orthoptics.
- Tests associated with the fitting of contact lenses, unless the contact lenses are needed due to eye surgery or to treat accidental injury.
- Sunglasses or safety glasses and accompanying frames of any type.
- Any nonprescription lenses, eyeglasses or contacts or Plano lenses or lenses that have no refractive power.
- Any lost or broken lenses or frames.
- Cosmetic lens options that are not otherwise specifically listed as covered.

- Any frame in which the manufacturer has imposed a no discount policy.
- Services needed for employment or given by a medical department, clinic or similar service provided or maintained by the employer or any government entity.
- Any other vision services not specifically listed as covered.
- For members through age 18, there is no benefit for frames or contact lenses purchased outside of our drug list (formulary).

Waived cost shares

Your coverage does not include waived cost shares when you receive services from a provider outside of your plan and this provider waives the copay, coinsurance or deductible usually required by this plan.

Weight-loss programs whether or not you join them under medical or physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to, commercial weight-loss programs (Weight Watchers®, Jenny Craig®, LA Weight Loss®, etc.) and fasting programs.

Work-related injuries or diseases

Services or supplies if they're for **work-related injuries** or diseases when the employer must provide benefits as required by federal, state or local law or when you've been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not you reach a settlement with your employer or the employer's insurer or self-insurance association because of the injury or disease.



The ins and outs of coverage

(continued)

Besides the above exclusions, certain items are not covered under the prescription drug retail or home delivery (mail order) pharmacy benefit:

Prescription drug exclusions

- **Administration charges:** Charges for the administration of any drug except for covered immunizations as approved by us or the pharmacy benefits manager (PBM).
- **Charges not supported by medical records.** Charges for services not described in your medical records.
- **Clinically equivalent alternatives.** Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. Clinically equivalent means drugs that, for most members, will give you similar results for a disease or condition. If you have any questions about whether a certain drug is covered and which drugs fall into this group, visit our website at [anthem.com](https://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.
- **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 multisource, nonproprietary vehicles and/or pharmaceutical adjuvants.
- **Contrary to approved medical and professional standards:** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Delivery charges:** Charges for delivery of prescription drugs.
- **Drugs given at the provider's office or 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 the doctor. This exclusion does not apply to drugs used with diagnostic services, drugs used during chemotherapy in the office, or drugs covered under the medical supplied benefit; those would be covered services.
- **Drugs not on the Anthem prescription drug list (a formulary):** You can get a copy of this list by calling us or visiting us at [anthem.com](https://www.anthem.com). If you or your doctor believes you need a certain prescription drug not on the list, please refer to the *Prescription drug benefits at a retail or home delivery (mail order) pharmacy* section in your post-enrollment *Evidence of Coverage* or *Member Booklet* for details on requesting an exception.
- **Drugs over the quantity or age limits:** Drugs which are over any quantity or age limits set by your coverage or by us.
- **Drugs over the quantity prescribed or refills after one year:** Drugs in amounts over the quantity prescribed, or for a refill given more than one year after the date of the original prescription order.
- **Drugs prescribed by providers lacking qualifications, registrations or certifications.** Prescription drugs prescribed by a provider who does not have the necessary qualifications, registrations and/or certifications, as determined by us.
- **Drugs that do not need a prescription.** Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- **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.



The ins and outs of coverage

(continued)

- **Gene therapy.** Gene therapy as well as any drugs, procedures and health care services related to it that introduce or are related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- **Infertility treatments:** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- **Items covered as durable medical equipment (DME):** Therapeutic DME, devices and supplies except peak-flow meters, spacers and blood glucose monitors. Items not covered under the prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit may be covered under the medical equipment (durable) or medical supplies benefit.
- **Items covered under the medical supplies and medications benefit:** Allergy desensitization products or allergy serum. While not covered under the prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit, these items may be covered under the medical supplies and medications benefit.
- **Lost or stolen drugs:** Refills of lost or stolen drugs.
- **Mail order providers other than our home delivery provider:** Prescription drugs dispensed by any home delivery provider other than our home delivery provider unless we must cover them by law.
- **Nonapproved drugs:** Drugs not approved by the FDA.
- **Nonmedically necessary services:** Services which we conclude are **not medically necessary**. This includes services that do not meet our medical policy, clinical coverage or benefit policy guidelines.
- **Nutritional or dietary supplements:** Nutritional and/or dietary supplements except those otherwise noted as being covered 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 from a licensed pharmacist.
- **Off-label use:** Unless we must cover the use by law or if we, or the pharmacy benefits manager, approve it.
- **Onychomycosis drugs:** Drugs for onychomycosis (toenail fungus), except when we allow it to treat members who are immuno-compromised or diabetic.
- **Over-the-counter items:** Drugs, devices and products, or prescription legend drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device or product. This includes prescription legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over-the-counter products that we must cover under federal law with a prescription.
- **Sexual dysfunction drugs:** Drugs to treat sexual or erectile problems.
- **Syringes:** Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- **Weight-loss drugs:** Any drug mainly used for weight loss. 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.



Let's talk about your privacy and rights

Safeguarding your information

As a member, you have the right to expect us to protect the privacy of your personal health information. We do this according to state and federal laws, and our 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 www.anthem.com/memberrights. To ask for a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). Doctors and pharmacists who want to be sure you get the best treatments for certain health conditions make up Anthem's UM team. They review the information your doctor sends us. These reviews can be done 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 learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more detailed information about how we help manage your care, visit www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.



We've got your back!

Anthem 
And Its Affiliate HealthKeepers, Inc.

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

These policies have exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: Group Policy GP-1 (7/02), GP-TOC, GP-ELIG (10/17) and GP-GEN (10/17), PP-INTRO (10/17), P-TOC (1/15), P-SBG (10/17), P-WORKS (10/17), P-COVERED (10/17), P-EXCL (10/17), P-CLAIMS (10/17), P-COB (1/16), P-ENR (10/17), P-ENOS (1/17), P-INFO (1/17), P-RIGHTS (1/17), P-DEF (10/17), P-EXH-A (1/17), P-INDEX (7/10). Enrollment application used for these plans: 490773 (10/17), 490773 (7/15). This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area. Life and Disability products underwritten by Anthem Life Insurance Company. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.