



2025 open enrollment

Your guide to your health plan and benefits

Anthem Benefit Guide
Floyd County Public Schools

October 1, 2025

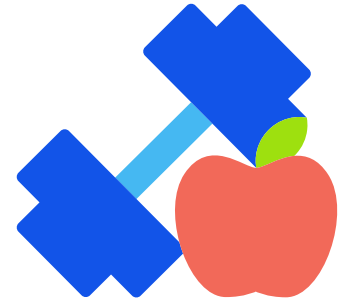


Welcome to Anthem

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

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

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



Why Anthem

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

The nation's largest network

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

No- or low-cost preventive care

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

Convenient virtual care

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

Health and wellness programs

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

¹ Elevance Health website: *Advancing Health Together* (May 2023): advancinghealth.elevancehealth.com.

² Blue Cross Blue Shield Association: *About Us: The Blue Cross Blue Shield System*: [bcbs.com](https://www.bcbs.com).

³ Virtual text and video visits powered by K Health. LiveHealth Online is the trade name of Carelon Health Solutions, Inc., a separate company, providing telehealth services on behalf of your health plan.

⁴ In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

⁵ LiveHealth Online, internal data (2023).



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Medical plans

Review your options to find the right fit for your needs

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

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

KeyCare

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

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

Health Savings Account (HSA)

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

- The money in your HSA rolls over from year to year and is yours to keep, even if you change health plans or jobs, or retire.

- You can contribute up to \$4,300 for an individual and \$8,550 for a family. If you're 55 or older, you can contribute an extra \$1,000 a year.

Healthcare terms

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

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

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

Primary care doctor: A doctor you see regularly for checkups and minor illnesses and injuries. Learn more healthcare terms online at [anthem.com/glossary](https://www.anthem.com/glossary).

Find care



Use our **Find Care** tool to see if your doctors are in the plan's network by visiting [anthem.com/find-care](https://www.anthem.com/find-care)

¹ For a full list of qualified expenses, go to [anthem.com/qme](https://www.anthem.com/qme).

² There are plans that require you to pay a copay at the time of service.



Pharmacy benefits

Reliable prescription drug coverage

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

Your plan covers:

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

Coverage requirements

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

- **Preapproval, also known as prior authorization:** This means Anthem needs to approve a drug before the pharmacy fills it.

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

Tips: How to get your prescriptions and save money

- **Retail pharmacies:** Your costs may be lower with pharmacies in your plan's network.
- Price a medication tool on **anthem.com** or the **SydneySM Health** app.
- **Noncovered medicine:** If your prescription isn't covered by your plan, you may be able to receive a discount. Share your ID card at the pharmacy, and the available discount will automatically be applied.
- Check for generic instead of brand name medicines, which are just as effective and can save you money.

To understand pharmacy benefits:

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

Your pharmacy options

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

The **Base Network** is our national pharmacy network with nearly 70,000 retail pharmacies across the country.

To find a pharmacy, visit

[anthem.com/pharmacyinformation/rxnetworks.html](https://www.anthem.com/pharmacyinformation/rxnetworks.html)

and choose the Base Network list.

Plan extras and workplace perks

Extra benefits that support your whole health

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

Condition support

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

24/7 NurseLine

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

Autism Spectrum Disorder Program

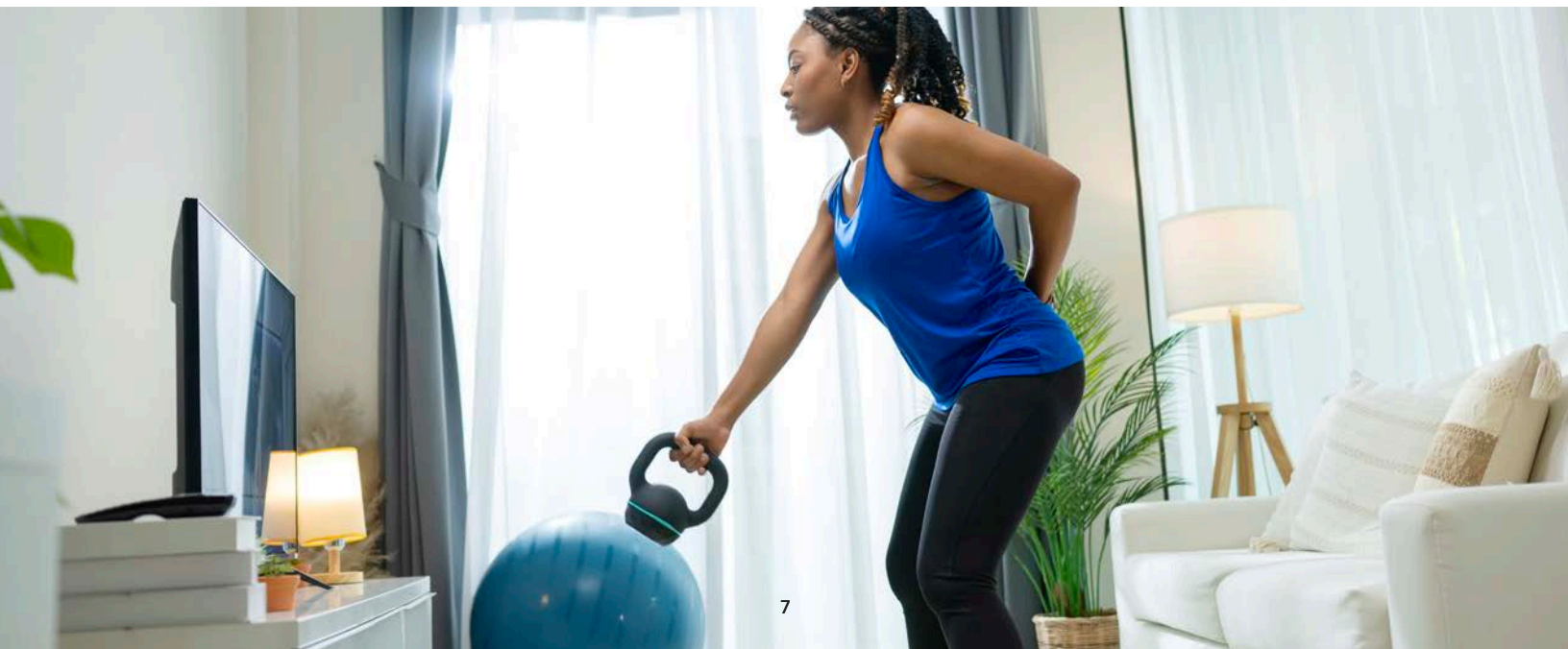
This program focuses on building a strong support system for the entire family. A specialized team of clinicians will work with you to create a customized care plan, help coordinate care, and connect you with resources in your community.

Case Management

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

ConditionCare CORE

A dedicated care management team, including dietitians, health educators, and pharmacists, is available to help you learn about and manage chronic health conditions, such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, or heart failure. You can also earn \$100 when you enroll and \$200 when you finish the ConditionCare program.



ConditionCare End-Stage Renal Disease

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

Maternity

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

Building Healthy Families

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

Behavioral health

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

Behavioral Health

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

Emotional Well-being Resources

Emotional Well-being Resources is here to help you identify the thoughts and behavior patterns that affect your emotional well being — and work through them with online programs and personalized coaching. Learn effective ways to manage stress, depression, anxiety, and sleep issues.

Whole health connections

Staying on top of your health is important but can sometimes be hard to do on your own. We connect you to the right resources that can help you more easily meet your goals.

MyHealth Advantage

Stay healthy and save money with this no-cost service that can remind you when you need to refill a prescription or have a checkup, test, or exam. You'll also receive personalized and confidential MyHealth Notes.

SpecialOffers

SpecialOffers features discounts on a variety of programs that help promote better health and well-being. Discounts are available on products and services for dental, vision, hearing, weight loss, fitness, family planning, pet insurance, health supplements, and skincare.

Well-being Coach

A well-being coach provides practical tips and tailored support to help you achieve your wellness goals — like quitting tobacco or losing weight. You'll even have access to a coach that can help you reach your individual wellness goals.

Workplace extras

Your workplace extras provide additional benefits and layers of support to help you no matter what life brings your way.

Employee Assistance Program

When you or those in your household face personal or work-related challenges, such as a family concern, work situation, or financial question, your Employee Assistance Program (EAP) is available to help you anytime, from anywhere.

Plan tools and resources

Make the most of your benefits

Your health plan comes with tools and resources that make it easier to access your benefits and find care.

Find Care

Our **Find Care** tool is a great way to find care providers in your health plan's network. Even if you haven't yet enrolled, using this tool to see if your current care providers are in the plan's network can help you make the right choice during open enrollment and save you money on care. Search by the doctor's name or specialty, type of procedure, or facility. If you don't yet have an Anthem health plan, you can still access the Find Care tool on [anthem.com/find-care](https://www.anthem.com/find-care) and search as a guest.

- Select **Basic search**.
- Select the type of plan or network — **Medical Plan or Network** — then select the state in which your employer's plan is contracted. Most often it's where the company's headquarters are located.
- Select how you get health insurance, which is Medical (Employer Sponsored).
- Choose a plan or network by entering the Medical. Then select the **Continue** button.
- Enter your *city, county, or ZIP code*. You also can search by doctor or procedure, as well as using other care-related terms.
- View results.

SydneySM Health app

Once you have an Anthem health plan, you'll be able to access your benefits and digital health plan ID card, wellness resources, and the **Find Care** tool with the **SydneySM Health** app.

The app brings your benefits and health information together in one convenient place and works with you to guide you to better overall health.

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 8DBR

Your Plan: Anthem KeyCare 25 1500/20%/6000 Rx \$15/\$50/\$85/25%

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$50 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$1,500 person / \$3,000 family	\$3,000 person / \$6,000 family
Overall Out-of-Pocket Limit	\$6,000 person / \$12,000 family	\$12,000 person / \$24,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Preferred PCP <i>virtual and office</i> (Providers reflected in our FindCare tool as: EPHC Providers)	\$15 copay per visit medical deductible does not apply	Not covered
Primary Care (PCP) <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Care <i>virtual and office</i>	\$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u> Maternity Doctor services (prenatal/postnatal care and delivery) Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	20% coinsurance after medical deductible is met \$25 copay per visit medical deductible does not apply \$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	\$15 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab Office Reference Lab	No charge No charge	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> <i>Urgent Care includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance <i>Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	\$50 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i> Office Outpatient Hospital	\$25 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National Direct Plus Drugs not included on the National Direct Plus drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<p>Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</p> <p>Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. This service is optional. You will need to call us on the number on your ID card to sign up when you first use the service. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</p>		
Tier 1 - Typically Generic	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$50 copay per prescription (retail) and \$125 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$85 copay per prescription (retail) and \$213 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$400 per prescription (retail and home delivery)	40% coinsurance (retail) and Not covered (home delivery)

- Notes:
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".

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

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

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

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

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956

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

(TTY/TDD: 711)

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

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

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。

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

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

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.

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。

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

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj'í bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (833) 592-9956.

Language Access Services:

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

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, (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।

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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.

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Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 8DEB

Your Plan: Anthem KeyCare 45 5000/20%/8700 Rx \$15/\$50/\$85/25%

\$250/\$500 Ded Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	\$70 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$5,500 person / \$11,000 family	\$11,000 person / \$22,000 family
Overall Out-of-Pocket Limit	\$8,700 person / \$17,400 family	\$17,400 person / \$34,800 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Preferred PCP <i>virtual and office</i> (Providers reflected in our FindCare tool as: EPHC Providers)	\$35 copay per visit medical deductible does not apply	Not covered
Primary Care (PCP) <i>virtual and office</i>	\$45 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$45 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Care <i>virtual and office</i>	\$70 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u> Maternity Doctor services (prenatal/postnatal care and delivery) Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	20% coinsurance after medical deductible is met \$45 copay per visit medical deductible does not apply \$45 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	\$35 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab Office Reference Lab	No charge No charge	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> <i>Urgent Care includes doctor services. Additional charges may apply depending on the care provided.</i> Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance <i>Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i>	\$70 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i> Office Outpatient Hospital	\$45 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible Applies to Tiers 2, 3 and 4	\$250 single/\$500 family	\$250 single/\$500 family
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National Direct Plus Drugs not included on the National Direct Plus drug list will not be covered.</i>		
Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<p>Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</p> <p>Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. This service is optional. You will need to call us on the number on your ID card to sign up when you first use the service. Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</p>		
Tier 1 - Typically Generic	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$50 copay per prescription deductible applies (retail) and \$125 copay per prescription deductible applies (home delivery)	40% coinsurance deductible applies (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$85 copay per prescription deductible applies (retail) and \$213 copay per prescription deductible applies (home delivery)	40% coinsurance deductible applies (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$400 per prescription deductible applies (retail and home delivery)	40% coinsurance deductible applies (retail) and Not covered (home delivery)

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), **benefits for Covered Services will be paid under “Outpatient Facility Services”**.

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

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

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

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

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956

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

(TTY/TDD: 711)

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

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

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。

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

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

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.

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.

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

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj'í bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (833) 592-9956.

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Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 8DCS

Your Plan: Anthem HSA 4000/20%/7000 Rx Ded/\$15/\$50/\$85/25%

Your Network: KeyCare

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$4,000 person / \$8,000 family	\$8,000 person / \$16,000 family
Overall Out-of-Pocket Limit	\$7,000 person / \$14,000 family	\$14,000 person / \$28,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Reference Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services</p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance <i>Non-emergency Out-of-Network ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Outpatient Mental Health and Substance Use Disorder Services at a Facility</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Physician and other services <i>including surgeon fees</i></p> <p>Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Combined with In-Network medical deductible</p>	<p>Combined with Out-of-Network medical deductible</p>
<p>Pharmacy Out-of-Pocket Limit</p>	<p>Combined with In-Network medical out-of-pocket limit</p>	<p>Combined with Out-of-Network medical out-of-pocket limit</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<p>Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National Direct Plus</i> <i>Drugs not included on the National Direct Plus drug list will not be covered.</i></p>		
<p>Day Supply Limits: Retail Pharmacy <i>30 day supply (cost shares noted below)</i> Retail 90 Pharmacy <i>90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> Home Delivery Pharmacy <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. This service is optional. You will need to call us on the number on your ID card to sign up when you first use the service.</i> Specialty Pharmacy <i>30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.</i></p>		
Tier 1 - Typically Generic	\$15 copay per prescription after deductible is met (retail) and \$30 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$50 copay per prescription after deductible is met (retail) and \$125 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$85 copay per prescription after deductible is met (retail) and \$213 copay per prescription after deductible is met (home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$400 per prescription after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider

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

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

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

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. Independent licensee 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.

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

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Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956

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

(TTY/TDD: 711)

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

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

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。

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

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

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.

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。

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

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj'í bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo koj' hodiilnih (833) 592-9956.

Language Access Services:

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

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, (833) 592-9956 ਤੇ ਕਾਲ ਕਰੋ।

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.

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.

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.

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>.

Your Employee Assistance Program

Floyd County Public Schools

Your Employee Assistance Program (EAP) is here to help you and your household through difficult times. The following resources are private, confidential, and available to you 24/7 at no extra cost.¹



Counseling and mental health

- Get 3 free visits for in-person or virtual counseling per person in your household, per issue each year.²



Legal and financial resources

- Book a no-cost consultation and receive a discounted rate from participating local attorneys on continued legal services.³
- Explore an online library of legal resources, forms, and essential documents.
- Have unlimited phone consults with a financial professional and access online financial calculators and budgeting tools.



Work-life resources

- Find information on career, parenting, and balancing work and family.
- Find high-quality child, elder, and pet care.
- Receive special discounts on a range of products and services, including food, travel, and clothing.



24/7 crisis support

- Get in-the-moment support when experiencing a personal crisis.
- Find help with navigating resources and getting support if you're impacted by a tragedy or natural disaster.



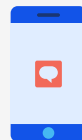
Identity theft support

- Register to get help with identity monitoring and theft resolution to minimize or recover from the effects of identity theft.



Self-improvement resources

- Log in to take self-assessments, access the Guidance to Care tool, and get a list of EAP resources specific to your needs.



Get the help you need, 24/7

- Visit [anthem.com/EAP](https://www.anthem.com/EAP) and log in with company name: Floyd.
- Call your EAP at **800-999-7222** for help with questions.



¹ In accordance with federal and state law, and professional ethical standards.

² Appointments are subject to availability of a therapist. Online counseling is not appropriate for all kinds of problems. If you are in a crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 988 (National Suicide Prevention Lifeline) and ask for help. If your issue is an emergency, call 911 or go to the nearest emergency room.

³ Excludes business, benefits, or employment issues. The free half-hour consultations apply per legal issue, per year. You are eligible for a new consultation for each new issue yearly.

This document is for general information purposes. Check with your employer for specific information on services available to you.

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

EAP products are offered by Anthem Insurance Companies, Inc.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., also HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc., and Anthem HealthChoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association, Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Making the choice to go paperless

Provide your preferred email when you enroll in benefits

Going paperless provides easier access to your plan documents, 24/7, so you can have greater peace of mind and confidence when managing your healthcare benefits. When there's a new or updated plan document available on your digital account, you'll receive an email with a link to view the details on our **SydneySM Health app** or our website, **anthem.com**. You will get instant updates and secure access to your:



Health plan ID cards. No more waiting for your ID card in the mail. You can download, fax, or email your digital card as needed or save it to the virtual wallet on your smartphone.

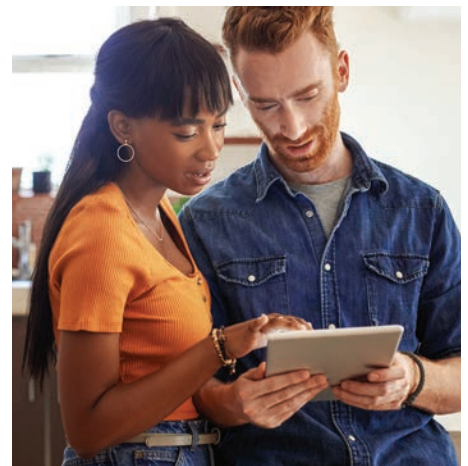


Explanation of benefits (EOBs). You can review an EOB as soon as it's available, helping you stay up to date on how your claims are processed and benefits are being applied.



Benefit updates and other legal information.¹ You will be able to review important plan details so you can stay informed on how to take full advantage of your benefits.

You may also receive other email communications about preventive screenings and well-being programs that can help you take care of your health.



Get started with paperless communications

To sign up for digital communications, provide your email address when you enroll in your health plan. You can update or change your preferred email anytime by going to your profile on the Sydney Health app or **anthem.com**.



Accessing your plan documents after enrollment

How to find your ID card online after logging in:

1. On Sydney Health, select the ID card button in the top right. On **anthem.com**, select **ID card** from the options on the right.
2. You can view your own ID card and cards for any plan dependents.
3. Choose whether you want to email, fax, or download your ID card.

How to find your explanation of benefits (EOBs) online after logging in:

1. On Sydney Health, go to the *Claims* tab. On **anthem.com**, go to the *Claims & Payments* tab.
2. Choose **Explanation of Benefits Center**.
3. You can choose to view medical, dental, pharmacy, or vision EOBs.²
4. Select the specific EOB you'd like to review.

If you'd like to receive paper documents and communications:

1. Log in to your account on Sydney Health or **anthem.com**.
2. On Sydney Health, type Profile in the chat feature. On **anthem.com**, choose **Profile** in the top right corner.
3. Scroll to the *My Account* section and choose *Communications & Settings*.
4. Under the *Plan Communications Settings* section, confirm your mailing address is correct.
5. Scroll to *Customize Going Digital* and select **Mail** for each communication you want to receive by mail. To switch them all, you can toggle the button under *Go 100% Digital* to off.

Note: You can keep your preference for digital communications and still request a paper copy of any document as needed. Simply chat with us on Sydney Health or **anthem.com** or call the Member Services number on your health plan ID card.

¹ May include plan documents and legally required communications like your plan contract, medical determination or grievance and appeals communications, and other information about your plan.

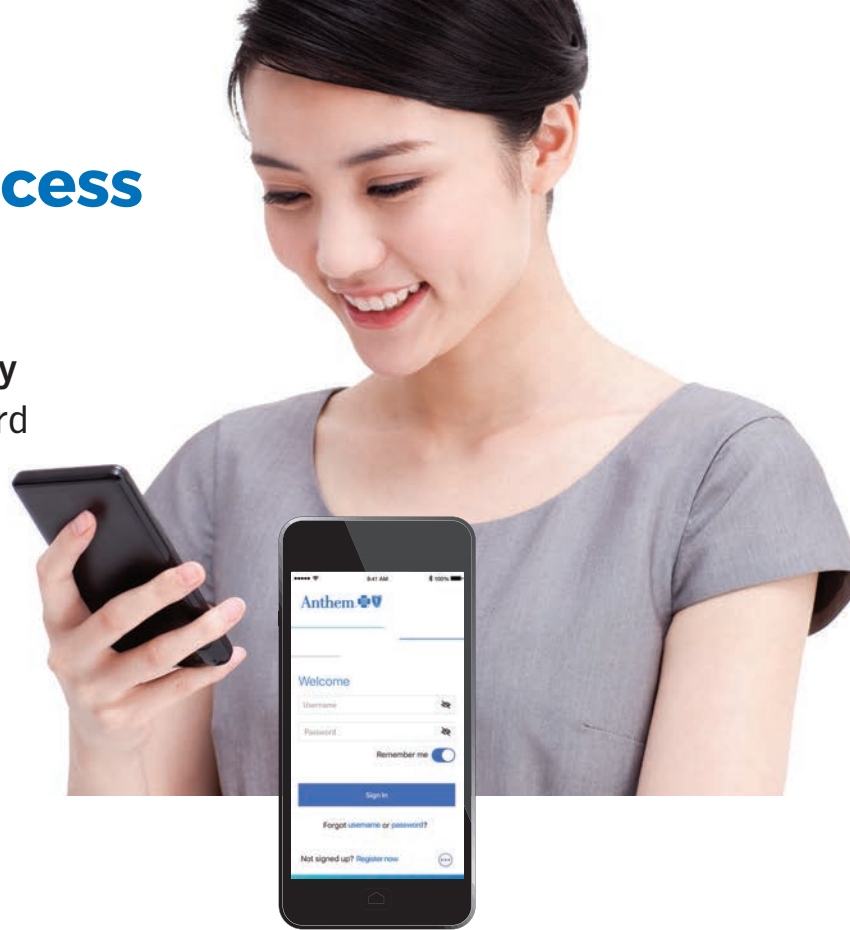
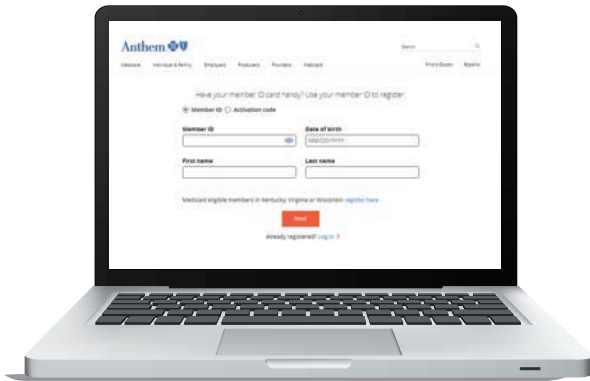
² An EOB email notification can only be sent for medical or dental Explanation of Benefits (EOB). EOBs for vision are not currently accessible online and will be mailed.

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

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem Healthchoice Assurance, Inc., and Anthem Healthchoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the tradename of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc. trades as Anthem HealthKeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

You've got quick access to your health care!

Register on **anthem.com** or the **Sydney** mobile app.* Have your member ID card handy to register



From your computer

- 1 Go to **anthem.com/register**
- 2 Provide the information requested
- 3 Create a username and password
- 4 Set your email preferences
- 5 Follow the prompts to complete your registration

From your mobile device

- 1 Download the free **Sydney** mobile app and select **Register**
- 2 Confirm your identity
- 3 Create a username and password
- 4 Confirm your email preferences
- 5 Follow the prompts to complete your registration

It's easy. Everything you need to know about your plan – including medical – in one place. Making your health care journey simple, personal – all about you.

Need help signing up?
Call us at **1-866-755-2680**.



* You must be 18 years or older to register your own account.

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When you need care quickly

Knowing where to go can save you time and money

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

Where to go for care

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

<p>PCP</p> <p>Usually available during normal business hours and may also provide medical advice by phone after hours</p>	<p>Virtual care</p> <p>24/7 access to doctors through the Sydney HealthSM app, no appointment needed</p>	<p>Retail health clinic</p> <p>Walk-in care clinics located in certain drugstores and major retailers</p>	<p>Urgent care center</p> <p>Stand-alone facilities, open extended hours</p>	<p>Emergency room</p> <p>Stand-alone facilities or part of hospitals, open 24/7</p>
				
<p>cost⁷ average wait²</p> <p>\$\$ 18 min</p>	<p>cost average wait³</p> <p>\$ 10 min</p>	<p>cost average wait⁴</p> <p>\$\$ 30 min</p>	<p>cost average wait⁵</p> <p>\$\$\$ 30 min</p>	<p>cost average wait⁶</p> <p>\$\$\$\$ 90 min</p>
<p>Mild asthma, back pain, flu-like symptoms, allergies, fever, sprains, diarrhea, eye or sinus infection, rash, urinary tract infection (UTI), sore throat, earaches, bumps, minor cuts and scrapes, and other nonemergency symptoms</p>	<p>Flu-like symptoms, allergies, fever, sinus pain, diarrhea, eye infection, rash, UTI</p>	<p>They help ensure tests Sore throat, earaches, bumps, minor cuts and scrapes, UTI</p>	<p>Sprain and strains, nausea, diarrhea, ear or sinus pain, minor allergic reactions, cough, sore throat, minor headache, UTI</p>	<p>Signs of a heart attack (chest pain) or stroke (sudden numbness and slurred speech), difficulty breathing, and severe burn or bleeding – and any other symptoms where it is reasonable to think you are having a life-threatening emergency or your health is in serious jeopardy</p>



How to find the care you need:

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



Did you know?

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



Learn more about your healthcare options

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



Sources:

1 The care options and list of symptoms are not all-inclusive. If possible, consult your PCP for more guidance.

2 Business Wire: *9th Annual Vitals Wait Time Report Released* (accessed July 2021): [businesswire.com](https://www.businesswire.com).

3 LiveHealth Online, internal data 2020.

4 Healthcare Finance: *Patient wait times show notable impact on satisfaction scores, Vitals study shows* (accessed July 2021): [healthcarefinancenews.com](https://www.healthcarefinancenews.com).

5 Urgent Care Association: *UCA 2019 Benchmarking Report* (accessed July 2021): [ucaa.org](https://www.ucaa.org).

6 Harvard Business Review: *To Reduce Emergency Room Wait Times, Tie Them to Payments* (accessed July 2021): hbr.org.

7 Costs are ranked according to the member's estimated out-of-pocket costs and average health plan copays. Each plan may have different costs. Nonemergency care outside of your network may cost more out of pocket or may not be covered at all. \$ = lower cost, and \$\$\$ = higher cost. Call the Member Services number on your ID card if you have questions about your plan.

8 Healthgrades: *Should You Go to the ER or Urgent Care? How to Decide* (accessed July 2021): [healthgrades.com](https://www.healthgrades.com).

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

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Stay on top of your health

Use your preventive care benefits



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

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

Preventive care vs. diagnostic care

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

Adult preventive care

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

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)^{2, 3}
- Depression screening
- Diabetes screening (type 2)⁴
- Eye chart test for vision⁵
- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Hepatitis C virus (HCV) screening
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for those ages 50 to 80 who have a history of smoking 20 packs or more per year and still smoke, or who have quit within the past 15 years²
- Obesity: related screening and counseling⁴
- Prostate cancer screenings, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

Women's preventive care:⁶

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met⁷
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling^{8, 9, 10}
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening⁹
- Interpersonal and domestic violence: screening and counseling
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV, and depression⁹
- Well-woman visits

Immunizations:

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

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

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

Child preventive care

Preventive physical exams, screenings, and tests:

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

Immunizations:

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

If you'd like more help understanding your preventive care benefits, call Member Services at the number on your ID card.

1 The range of preventive care services covered at 100% when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your *Certificate of Coverage* or call the Member Services number on your ID card.

2 You may be required to receive preapproval for these services.

3 The follow-up colonoscopy after a positive stool-based or direct visualization (such as a CT colonography or flexible sigmoidoscopy) colorectal cancer screening is considered a screening colonoscopy, meaning it is paid at 100% (so you pay no share of the cost) when provided by a doctor in the plan's network.

4 The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

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

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

7 Check your medical policy for details.

8 Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

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

10 Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay, or coinsurance). Contact the provider to see if such services are available.

11 You may pay a share of the cost for other prescription contraceptives, based on your drug benefits. Your share of the cost may be waived if your doctor decides that using the multisource brand or brand name is medically necessary.

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EnsureRx helps members save

Improving whole health through affordable prescription drugs



As many as 18 million Americans can't afford their prescriptions.¹ High costs are expected to continue, as prices on more than 1,200 medicines rose an average of 31% between July 2021 and July 2022.²

Members often turn to prescription discount cards outside their health benefits to afford their prescriptions. This can lead to reduced claims visibility and higher spending, as out-of-pocket costs do not apply to the member's deductible.

EnsureRx is here to help

There is a convenient new way to increase transparency and save up to 51% on select generic prescription drugs without having to shop around.³ EnsureRx automatically compares costs against multiple discount cards through the EnsureRx cash wrap discount card network and applies the best price for members.

EnsureRx provides a seamless, no-hassle experience. The program is integrated into the member benefit automatically. The amount paid applies to the member's deductible, which saves time and money, and applies across the full benefit.

Affordable medicine through plan benefits

EnsureRx helps lower the cost on the prescriptions members need. Clients experience lower drug spend, as utilization and spend to discount card networks are offset.

The EnsureRx experience

EnsureRx eliminates the need to use third-party discount cards. Members simply use their insurance benefits to receive the discount for select generic prescriptions.



EnsureRx discount applied automatically at the pharmacy counter



Member pays the lowest available cost at pick-up, and those costs are applied to the accumulator and deductible across the full benefit



Claim is captured to ensure patient safety protocols

Anthem

carelon
Rx

¹ Westhealth website, *18-million Americans Can't Pay for Needed Meds* (accessed May 2023); westhealth.org.

² Office of the Assistant Secretary for Planning and Evaluation website, *Price Increases for Prescription Drugs, 2016-2022* (accessed May 2023); aspe.hhs.gov.

³ Internal data, 2022.

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Quest[®]

Join the in crowd

Quest is now in-network with Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. in Virginia.

We made it easier than ever to better manage your health.

When Anthem members in Virginia choose Quest[®] for in-network lab tests, you can expect low or no out-of-pocket costs. With more than 40 locations in Virginia, there's a Quest near where you live and work. This means you now have greater access to insights you and your doctor can trust.

Better health at your fingertips with MyQuest[®]

- Get easy-to-understand lab results delivered directly to you
- Schedule lab testing at a time convenient for you
- Share your health information with your healthcare providers
- Organize your health information in one convenient place
- Schedule and receive medication reminders
- View your lab results back to 2010 with Advanced Access

Sign up today at MyQuest.QuestDiagnostics.com

Use the QR Code to learn how Quest can help you better manage your health.



Schedule lab tests for a convenient time and location.



Schedule testing at a time convenient for you
QuestDiagnostics.com/Appointment



Receive lab results through the MyQuest online portal or app



Build your personal health history and share health information with your doctors

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The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

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

Find Care

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

My Health Dashboard

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

Chat

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

Virtual Care

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

Community Resources

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

My Health Records

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



Download the Sydney Health app today

Use the app anytime to:

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



Scan the QR code to download the Sydney Health app.

You can also set up an account at [anthem.com/register](https://www.anthem.com/register) to access most of the same features from your computer.

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

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Receive virtual care and support 24/7 with our Sydney Health app

Now you can connect more easily to the care you need through our **SydneySM Health** mobile app. Have a video visit with a doctor on your mobile device or computer with a camera, 24/7.

Visit with a doctor for common health concerns

Doctors are available anytime, with no appointments or long wait times. They can help you with these types of conditions:

- COVID-19
- Flu
- Cold and fever
- Minor rashes
- Sore throat
- Headaches

During your video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed.¹



What people say about virtual care visits²

89%

said the doctor they saw was professional and helpful

92%

thought the doctor understood their concerns

92%

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

How to download our Sydney Health app:



Scan the QR code with your phone's camera.



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

Download our no-cost **Sydney Health** app.

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

Visit **anthem.com**.

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



¹ Prescription availability is defined by physician judgment.

² Based on Sydney Health utilization trends from top national clients.

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

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Having a primary care doctor makes a difference






Stay healthy and help lower your healthcare costs over time with a PCP

The right doctor can have a positive impact on your health and well-being. Choosing one in your plan can save you money as well. The following information can help you find a doctor who is a good fit for you and your family.

Why you should have a primary care doctor

A primary care provider (PCP) serves as your main doctor and is your first stop when you need care.

When you see the same doctor over time, they can:

<p>See the full picture of your health</p>	<p>Save you time and money</p>	<p>Coordinate your care or treatments</p>	<p>Help you avoid costly ER visits</p>	<p>Assist you after hours</p>
<p></p> <p>They know your health history and can connect the dots quickly if you have a health issue.</p>	<p></p> <p>A PCP helps you stay healthy with preventive care and can help manage chronic conditions and medications.</p>	<p></p> <p>They help ensure tests aren't needlessly repeated, your medicines work well together, and your other doctors agree on your health needs.</p>	<p></p> <p>Call your PCP first when you have an illness, minor injury, or flare-up of a chronic condition. They can advise you where to go for care.</p>	<p></p> <p>Many PCPs now have evening and weekend hours. Some may also offer telehealth virtual visits.</p>

The main types of primary care doctors include:

- **Family practitioners and general practice doctors** treat people of all ages. This type of doctor might be a good choice if you want to keep your family's care "under one roof."
- **Internal medicine doctors**, also called internists, treat adults and may have special knowledge about certain health problems. If you have a long-term health condition, an internist who specializes in your issue may be a good fit.
- **Pediatricians** specialize in caring for children, from birth to early adulthood.



What to consider when choosing your doctor

Every doctor is different. Take time to find a doctor who makes you feel comfortable, listens to your needs, and explains things clearly. It's also important to find out if the doctor:

- Is part of your health plan's network. You'll pay less out of pocket for your visits, preventive care screenings, vaccines, and annual physicals. If your doctor is not in your plan's network, you may not be covered at all.
- Has the training and background to treat your health problems.
- Has an office in a convenient location, close to your home or work.
- Holds office hours that work with your schedule.
- Offers telehealth options, such as text, email, phone, or video visits.

You can visit different doctors in your plan's network to find the one who is right for you. If you're not happy with your first choice, it's okay. You may be able to change your primary care doctor depending on your plan.



Three ways to find a doctor in your plan:

1. Download the Sydney HealthSM mobile app, log in, and select **Find Care**.
2. Call Member Services at the number on your ID card.
3. Scan the QR Code below or log in at **anthem.com** and choose **Find Care**.



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



Your plan covers telehealth visits

Virtual care, also known as telehealth, is a simpler way to talk to a doctor and can be a good option for some urgent issues. Ask your doctor if they offer telehealth visits. You can also access telehealth 24/7 through the Sydney HealthSM mobile app.

If you believe you are having a life-threatening emergency or your health is in serious jeopardy, call 911 immediately.

Sources:
WebMD website: *How to Choose a Doctor* (accessed July 2021): webmd.com
Centers for Disease Control and Prevention website: *Regular Check-Ups are Important* (accessed July 2021): cdc.gov/family/checkup.

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Your benefits go with you

With the BlueCard PPO and Blue Cross Blue Shield Global Core programs



If you're away from home and you need care right away, as an Anthem member, you have access to care across the country through the BlueCard® preferred provider organization (PPO) program. This includes 1.7 million doctors and hospitals — more than any other insurer.¹

How to access care across the U.S.:



Call 911 or go to the nearest hospital in an emergency.²



Log in to [anthem.com](https://www.anthem.com) and use the Find a Doctor tool to search for a doctor or hospital in the BlueCard PPO program.



Use the [SydneySM Health](#) app to search for a BlueCard PPO program doctor or hospital. Get turn-by-turn directions to the nearest doctor, urgent care center, or emergency room.



Call Member Services at the number on your health plan ID card.

When you're outside the U.S., the Blue Cross Blue Shield Global® Core program gives you access to preferred doctors and hospitals in nearly 190 countries and territories around the world.³

Need care outside the U.S.? You can:



Go straight to the nearest hospital in an emergency.



Go to [bcbsglobalcore.com](https://www.bcbsglobalcore.com) to search for a doctor or hospital.



Use the Blue Cross Blue Shield Global Core app to find a doctor or hospital.



Call the Blue Cross Blue Shield Global Core Service Center 24/7 at **800-810-2583 (BLUE)** or call collect at **804-673-1177**. They can help you set up a doctor visit or hospital stay.

Download the Blue Cross Blue Shield Global Core app today

With it, you can:

- Search for a doctor or hospital.⁴
- Submit claims.
- Get translations for medical terms — including symptoms and phrases — and even use an audio feature to play the translation.⁴
- Find a drug's generic name and local brand name, and check whether it's available.
- Learn how to find and contact a U.S. embassy.



Unless it's an emergency, call the Global Core Service Center before getting care outside the U.S. Global Core will work with the doctor and Anthem to approve and accept a Guarantee of Payment (GOP). If you get care from a doctor or hospital that has not accepted a GOP, you will need to:

- 1 Pay the full cost of your care upfront.
- 2 Download an international claim form at bcbsglobalcore.com or request a form by calling Member Services at the number on your ID card.
- 3 Fill out the claim form and send it with the original bills to the Blue Cross Blue Shield Global Core Service Center. You can submit them through the mobile app, email, or postal mail.



Traveling? Here's what you need to know:

- Before leaving the country, ask Member Services if your international benefits are different.
- Ask for approval before getting care. This is “preapproval” and helps you find care covered by your plan. To see if you need preapproval, call Member Services at the number on your ID card.
- Save money by seeing a BlueCard program doctor or hospital. You only pay your usual out-of-pocket amounts (such as deductible, your percentage of costs, or copay). If you go to a doctor or hospital outside the program, you'll need to pay the entire bill upfront.
- Show your Anthem ID card so the doctor or hospital can check your benefits and send us a claim for processing.

Remember to carry your ID card

The “PPO-in-a-suitcase” symbol shows you can get care from BlueCard PPO program doctors and hospitals.



Anthem  
HealthKeepers
Offered by HealthKeepers, Inc.

¹ Blue Cross Blue Shield Association: *The Blue Cross Blue Shield System* (accessed May 20, 2024); bcbs.com.

² You or a family member need to call the Member Services number on your ID card within 24 hours (48 hours for members in Indiana) after going to the hospital or as soon as you can.

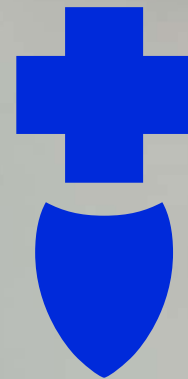
³ GeoBlue: *More than 25 years as a leader in international healthcare* (accessed May 20, 2024); about.geo-blue.com.

⁴ Using the Blue Cross Blue Shield Global Core app itself does not require an internet connection. However, using GPS for mapping or downloading an audio translation does require an internet connection. See bcbsglobalcore.com/home/mobileapp/#features.

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Get the lowest available cost on prescriptions with your CarelonRx pharmacy benefits



Maximize your prescription savings

CarelonRx is included as part of your Anthem Health benefits. We have programs in place that automatically compare discount cards in our network to ensure you're getting the lowest available cost on your medications. You can use the Price a Medication tool in the SydneySM Health app or go online to:

- Find discounts on hundreds of covered and non-covered drugs.
- Find the best in-network prices for your medications.
- Compare the costs of generic vs. brand name drugs.
- Save money on your maintenance medications with CarelonRx Pharmacy home delivery.

Get started today

To start saving, scan the QR code below or log into your account and select **Price a Medication** from the Prescriptions menu.



Get the most from your benefit plan. To learn more, log in to [anthem.com](https://www.anthem.com) or download the **Sydney Health app** on your phone or tablet.



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Cancer Care Navigators

Supporting you through your cancer experience

If you are facing cancer, we'd like to help make your life less stressful during this time. Anthem's Cancer Care Navigators are ready to help manage your care, so you can focus on your well-being. The program is included with your benefits, and it comes at no extra cost.

Cancer Care Navigators are health educators specially trained to understand your diagnosis and unique needs. They can:

- Coordinate your care and act as a single point of contact for you, your oncologist, and your care team.
- Support both your emotional and physical health.
- Connect you and your loved ones to community resources.
- Answer questions about your treatment, medication, side effects, as well as Anthem benefits.
- Help prevent unnecessary procedures, tests, and emergency room or hospital visits.

Wherever you are with your cancer diagnosis, Anthem's Cancer Care Navigators are here to support you with compassion and empathy. To learn more about the program, call **833-649-0669**.



Anthem 

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

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Every experience is different, but here is what working with a Cancer Care Navigator may look like:



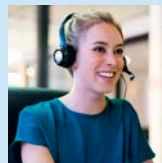
Meet Shelley. She has breast cancer.

Based on her diagnosis and treatment plan, Shelley is at high risk for having issues with chemotherapy. To support her through treatment, Shelley is assigned a personal Cancer Care Navigator named Melissa.



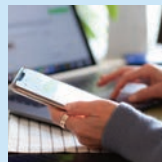
Melissa contacts Shelley's oncologist to learn more about her situation.

She finds out Shelley's doctor has been handling her transportation for chemotherapy appointments but is now too busy to provide the service.



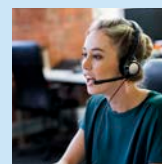
Melissa then calls Shelley to introduce herself, explain her role, and see how Shelley is coping.

Melissa wants to make sure she is aware of Shelley's unique circumstances and any concerns she may have about care. As they talk, Shelley reveals she has been struggling with anxiety. Melissa listens, reassures her, and schedules another call.



Melissa reaches out to Shelley for the second time and tells Shelley she has scheduled transportation for her next chemotherapy appointment.

Melissa mentions that Shelley has behavioral health resources through her health plan, including access to telehealth services and 24/7 NurseLine. Melissa emails links to Shelley for local support groups and sets up her third chemotherapy appointment.



Melissa follows up with Shelley's oncologist about her new transportation arrangement and growing anxiety.

The oncologist reports that Shelley has not been taking her medication regularly. Melissa calls Shelley to find out why she may be having trouble. Melissa offers to give Shelley daily reminders and to check in with Shelley's oncologist to monitor her progress.

In this example, the Cancer Care Navigator helps improve Shelley's care and educate her about support services available to her.



Protecting your health and wellness

Discover no-cost programs that can help

Your health plan comes with programs to help you confidently care for your well-being. It doesn't matter what health issues you may be experiencing or even what stage of life you're in – there is a program for everyone.

ConditionCare

Managing chronic conditions, such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), or heart disease requires extra care and attention. To help you be at your best, the ConditionCare program offers free resources, including:

- 24/7 phone access to nurses who can address your health questions and concerns.
- Support from healthcare professionals to help you reach your health goals.
- Educational guides and useful tools to help you learn more about a certain condition.



Connect with the support you need

- 24/7 NurseLine: **800-337-4770**
- ConditionCare: **866-960-0812**
- Find Building Healthy Families in your plan's mobile health app.



Building Healthy Families

Whether trying to conceive, expecting a child, or in the thick of raising young children, Building Healthy Families offers personalized, digital support to help each family navigate their unique journey. You can find Building Healthy Families in your plan's mobile health app to do things like:

- Track baby's feedings, diaper changes, and developmental milestones.
- Monitor prenatal health risks and receive updates on your pregnancy progress.
- Explore a library with thousands of educational articles and videos.
- Connect with one-on-one pregnancy support in the app or over the phone.



24/7 NurseLine

When your allergies flare up on the weekend or your little one spikes a fever at 3 a.m., you can ask a registered nurse for advice by calling 24/7 NurseLine. Nurses are ready any time of the day or night to:

- Answer your questions.
- Recommend where to go for care when your doctor isn't available.
- Help you find healthcare professionals in your area.
- Enroll you and your dependents in health management programs.
- Remind you about important preventive screenings and exams.

Enroll today

1. Visit [anthem.com](https://www.anthem.com) or log in to Sydney Health.
2. Find *Featured Programs* at the bottom of the homepage.
3. Select **View All** then choose the **Building Healthy Families** tile.

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



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Save money

with SpecialOffers and discounts

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



Vision, hearing, and dental

Eyewear

Glasses.com® and 1-800 CONTACTS®

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

EyeMed

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

LASIK

Premier LASIK Network

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

TruVision

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

Hearing

NationsHearing®

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

Hearing Care Solutions

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

Amplifon

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

Dental

RefreshaDent

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



Fitness and Health

Fitness

Active&Fit Direct™

Choose from thousands of participating gyms nationwide with no long-term contracts or annual fees, or get fit at home with access to 12,000+ on-demand workout videos at no cost.

Fitbit®

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

Garmin®

Discover discounts available on select Garmin wellness devices.

Husk Wellness

GlobalFit, by Husk Wellness, offers discounts on gym memberships, fitness equipment and technology, nutrition and mental health services, and virtual wellness solutions.

Health

Ahara

With a personalized nutrition plan, you can improve your health by discovering key nutrients your body needs along with hidden health risks. This includes a personalized meal plan tailored to your health goals and symptoms.

ChooseHealthy®

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

LifeMart®

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

▶ Learn more about SpecialOffers

Log in to [anthem.com](https://www.anthem.com), choose **Care**, and select **Discounts**.

Family and home

Family

23andMe®

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

WINFertility®

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

Home

Nationwide® pet insurance

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

ASPCA® Pet Health Insurance

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

Medicine and treatment

Medicine

Puritan's Pride®

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

Allergy Control Products and National Allergy Supply™

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

Treatment

The Living Well Courses

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

BREVENA

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

The ins and outs of coverage

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

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

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

Who can be enrolled

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

- Your spouse
- Your children age 26 or younger, including:
 - A newborn, natural child or a child placed with you for adoption
 - A stepchild
 - Any other child for whom you have legal guardianship
- Your domestic partner, if deemed eligible by your employer
- Your domestic partner and children, if deemed eligible by your group

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

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

The ins and outs of coverage

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

Renewed	Canceled	Changed	When
			Your employer: <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

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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

The ins and outs of coverage

Determining the primary and secondary plans

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

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

The ins and outs of coverage

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered

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

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

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

- **Administrative Charges**

- Charges to complete claim forms,
- Charges to get medical records or reports,
- Membership, administrative, or access Fees charged by Doctors or other Providers. Examples include, but are not limited to, Fees for educational brochures or calling you to give you test results.

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

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

- Acupuncture,
- Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
- Holistic medicine,
- Homeopathic medicine,
- Hypnosis,
- Aroma therapy,
- Massage and massage therapy,
- Reiki therapy,
- Herbal, vitamin or dietary products or therapies,
- Naturopathy,
- Thermography,
- Orthomolecular therapy,
- Contact reflex analysis,
- Bioenergetic synchronization technique (BEST),
- Iridology-study of the iris,
- Auditory integration therapy (AIT),
- Colonic irrigation,
- Magnetic innervation therapy,

What's Not Covered

- Electromagnetic therapy,
- Neurofeedback / Biofeedback.

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

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

- **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to:

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

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

What's Not Covered

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

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

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

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

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

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

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

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

What's Not Covered

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

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

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

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

- **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- **Hearing Aids** For Members age 19 or older, hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids and over-the-counter hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- **Hearing Aids** Over-the-counter hearing aids.
- **Home Health Care**
 - Services given by registered nurses and other health workers who are not Employees of or working under an approved arrangement with a Home Health Care Provider.
 - Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.

What's Not Covered

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

What's Not Covered

- Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
- Home workout or therapy equipment, including treadmills and home gyms,
- Pools, whirlpools, spas, or hydrotherapy equipment,
- Hypoallergenic pillows, mattresses, or waterbeds,
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.
- **Private Hospital Room** A private hospital room.
- **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
 - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.
- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that HealthKeepers determines require in-person contact and/or equipment that cannot be provided remotely.
- **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services** Vision services not described as Covered Services in this Booklet.

What's Not Covered

- **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet. This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

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

What's Not Covered

If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.

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

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

- **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, benefits may be available under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” benefit. Please see that section for details.
- **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
- **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment (DME), Medical Devices and Supplies” benefit. Please see that section for details.
- **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
- **Non-approved Drugs** Drugs not approved by the FDA.

What's Not Covered

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

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

- **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
- **Specialty Drugs** Specialty Drugs for which another source of payment is available, including but not limited to, manufacturer and copay assistance programs. This Exclusion applies to the full amount charged for any such Drug, not just the amount of alternate assistance potentially available, and applies regardless of whether such alternate assistance is received or pursued unless the Plan Administrator has made an exception as noted under “Employer’s Sole Discretion” in the “General Provisions” section.
- **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.>



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Protecting your privacy

How we keep your information safe and secure

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

You also have certain rights and responsibilities when receiving your healthcare. To understand how we protect your privacy, rights, and responsibilities when receiving healthcare, and your rights under the Women's Health and Cancer Rights Act, go to [anthem.com/privacy](https://www.anthem.com/privacy). For a printed copy, please contact your benefits administrator or Human Resources representative.

How we help manage your care

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

For additional information about how we help manage your care, go to [anthem.com/memberrights](https://www.anthem.com/memberrights). To request a printed copy, please contact your benefits administrator or Human Resources representative.

Special enrollment rights

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

- **If you had another health plan that was canceled.** If you, your dependents, or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the

employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.

- **If you have a new dependent.** You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes.** You have a special period of 60 days to enroll after:
 - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible.
 - You (or your eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

For full details, read your plan document, which has all the details about your plan. You can find it on [anthem.com](https://www.anthem.com).

We're here for you – in many languages

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

Spanish

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

Chinese

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

Vietnamese

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

Korean

귀하는 자국어에 무료 지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog

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

Russian

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

Armenian

Դուք իրավունք ունեւ ստանալ անվճար օգնութեան ձեր լեզվով: Պարզապէս զանգահարե՛ք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշուած է ձեր ID քարտի վրա:

Farsi

حقى را دارى د تا به صورت رایگان به زبان مادری تان کمک درى افست . کافى است با شماره خدمات اعضا (Member Services) درج شده ارت شناسایى خود تماس بگیرى براى تائىل بى نایى دستى دى؟ مى توانى د ند را به فرمت هاى دى گى نى ز در خواست دهى د.

French

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

Arabic

أفئقو اللج حصول على مساعفة بل غتلك لمجمل على سوى العتقال برقم ءة ال أعضاء ال موجود على بطاقة ال هوىة. هل نضع على بصرى؟ لم أفئق لب أشكال أخرى من هذا ال مسند.

Japanese

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

Haitian

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

Italian

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

Polish

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

Punjabi

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

TTY/TTD:711

It's important we treat you fairly

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

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>



PROOF



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

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

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

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

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. and Community Care Health Plan of Georgia, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In 17 southeastern counties of New York: Anthem HealthChoice Assurance, Inc. and Anthem HealthChoice HMO, Inc. In these same counties Anthem Blue Cross and Blue Shield HP is the trade name of Anthem HP, LLC. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield, and its affiliate Healthkeepers, Inc. trades as Anthem Healthkeepers providing HMO coverage, and their service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI) underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in POS policies offered by CompCare Health Services Insurance Corporation. Compare underwrites or administers HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.