



# **Ready to choose** *your benefits?*

**We can point you in the right direction.**

KeyCare PPO and Anthem HSA  
County of Pulaski  
Effective July 1, 2019



## Let's take a look

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

In this guide, you'll find:

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

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





## The plans at a glance

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

### PPO

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

### HSA

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



### It's easy to get care in your plan

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

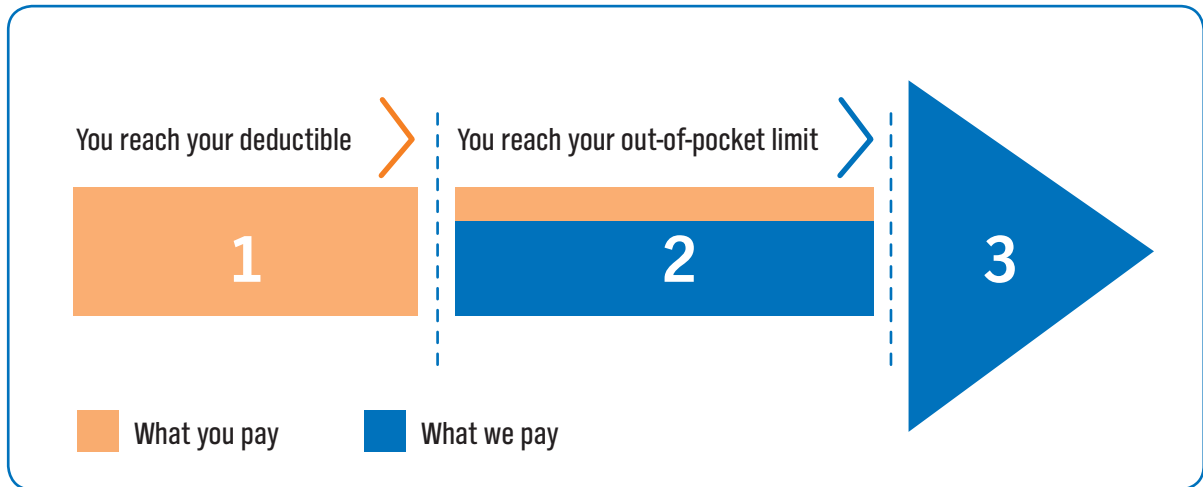
<sup>1</sup> Each of our plans may have different rules, so always check your plan details for more specific information.

<sup>2</sup> For a full list of qualified expenses visit [irs.gov/pub502](https://irs.gov/pub502). Veterans who have received medical benefits from the VA, due to a service-connect disability, are eligible to receive or make HSA contributions. Visit the IRS website at [irs.gov/irb/2004-33/IRB](https://irs.gov/irb/2004-33/IRB) for more information.



# Know your health care basics

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



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



## You pay your deductible.

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

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



## What happens after I pay my deductible?

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



## What's an out-of-pocket limit?

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



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

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



# Using your health plan

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



## Choose a doctor in your plan

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



## Use your ID card

Once your plan begins, access your mobile ID card on the **Engage Wellbeing app**. It's like your passport to care and you use it just like you would use a paper ID card. Simply show it when you go to your doctor's appointment.



## Register to use online tools and resources

Register on the **Engage Wellbeing app** and **anthem.com** to get personalized information about your wellness programs and health plan.

Use the self-service tools to:

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



## Preventive care is covered at no extra cost

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



## Save emergency room visits for emergencies only

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



## We're here for you

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

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



## Done driving to the doctor? Hey there, LiveHealth Online!

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

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

\*\*Prescription availability is defined by physician judgment.



## Vision benefits

When you enroll, you'll probably need to sign up separately for the benefits in this section.\*

### Vision

With Blue View Vision<sup>SM</sup>, you have access to over 38,000 doctors at over 27,000 locations across the country, including convenient retail stores like LensCrafters<sup>®</sup> Sears Optical<sup>SM</sup>, Target Optical<sup>®</sup>, JCPenney<sup>®</sup> Optical and most Pearle Vision<sup>®</sup> stores. You also can order glasses and contacts online through Glasses.com ([glasses.com](https://www.glasses.com)), ContactsDirect ([ContactsDirect.com](https://www.contactsdirect.com)) or 1-800-CONTACTS ([1800contacts.com](https://www.1800contacts.com)).

#### Enrolling in a vision plan helps you pay for:

- Routine eye exams. Even if you can see well, regular eye exams are important to help keep your eyes healthy - and you can catch other health problems early.

Blue View Vision's **International Travel Solution** helps you when traveling abroad.

- Find a trusted vision provider in 20 countries and territories.\*\*
- Get 24/7 phone support with translation services in 160 languages.
- If you lose or break your glasses, request free temporary emergency glasses with adjustable lenses. These can be delivered within 24 hours in most locations.



Your Anthem ID card gives you easy access to quality care from quality doctors.

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

\*\*Available in Australia, Austria, Brazil, Canada, Chile, China, Colombia, Ecuador, England, France, Germany, Hong Kong SAR, Italy, Japan, Mexico, New Zealand, Peru, Puerto Rico U.S., Spain, and Switzerland.



# Health and wellness programs support you along the way

Your plan goes way beyond covering doctor visits

We can help you reach your health goals and save money on health products and services. As a member, you have easy access to these programs and tools on the **Engage Wellbeing app** or by calling the Member Services number on your ID card.



**Engage Wellbeing app — Engage** This is your personalized health assistant that brings together all of your health care needs. Manage your benefits, health goals and monitor success with real-time reports all in one place. Get started by downloading the **Engage Wellbeing app**.



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



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



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



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



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



**The Weight Center** — From weight management support to discounts on fitness trackers, The Weight Center is a one-stop shop for advice, resources and much more - all at no cost to you. Download and register on the **Engage Wellbeing app** to get started.



**Online Wellness Toolkit** — The Online Wellness Toolkit gives you tools to set and achieve your unique health goals. It includes a Health Assessment for identifying health risks, guidance for lowering those risks, personalized trackers to monitor progress and fun activities that promote healthier decision-making.



**MyHealth Advantage** — Avoid health problems, stay healthy and save money. This program tracks your health information to see if there's anything you can do to improve your health. If so, you'll get a personalized and confidential MyHealth Note in the mail. Download the **Engage Wellbeing app** to receive your personalized, secure health messages on-the-go via the Mobile Inbox.



# Your plan details

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





The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/ft>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<a href="#">\$0</a> /single or <a href="#">\$0</a> /family for In-Network Providers. <a href="#">\$750</a> /single or <a href="#">\$1,500</a> /family for Non-Network Providers.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <a href="#">Prescription Drugs</a> for Non-Network Providers.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<a href="#">\$2,500</a> /single or <a href="#">\$5,000</a> /family for In-Network Providers. <a href="#">\$3,750</a> /single or <a href="#">\$7,500</a> /family for Non-Network Providers.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Pre-Authorization Penalties, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes, KeyCare. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 333-5735 for a list of network providers.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of-network <a href="#">provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of-network <a href="#">provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20/visit	30% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	\$40/visit	30% <u>coinsurance</u>	-----none-----
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$20/visit	30% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Tier 1 - Typically Generic	\$10/prescription <u>deductible</u> does not apply (retail) and \$10/prescription <u>deductible</u> does not apply (home delivery)	30% <u>coinsurance</u> <u>deductible</u> does not apply (retail and home delivery)	*See Prescription Drug section
	Tier 2 - Typically <u>Preferred/Brand</u>	\$30/prescription <u>deductible</u> does not apply (retail) and \$60/prescription <u>deductible</u> does not apply (home delivery)	30% <u>coinsurance</u> <u>deductible</u> does not apply (retail and home delivery)	
	Tier 3 - Typically Non- <u>Preferred/Specialty Drugs</u>	\$50/prescription <u>deductible</u> does not apply (retail) and \$150/prescription <u>deductible</u> does not apply (home delivery)	30% <u>coinsurance</u> <u>deductible</u> does not apply (retail and home delivery)	
	Tier 4 - Typically <u>Specialty</u> (brand and generic)	\$50/prescription <u>deductible</u> does not apply	30% <u>coinsurance</u> <u>deductible</u> does not apply (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$300/visit	30% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	\$40/visit	30% <u>coinsurance</u>	-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$250/visit	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	20% <u>coinsurance</u>	Covered as In-Network	-----none-----
	<u>Urgent care</u>	\$40/visit	30% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300/day up to \$1,500/admission	30% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	\$40/visit	30% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20/visit Other Outpatient No charge	Office Visit 30% <u>coinsurance</u> Other Outpatient 30% <u>coinsurance</u>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	\$300/day up to \$1,500/admission	30% <u>coinsurance</u>	-----none-----
	Office visits	\$300/preg	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you are pregnant	Childbirth/delivery professional services	\$40/visit	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$300/day up to \$1,500/admission	30% <u>coinsurance</u>	
	Home health care	20% <u>coinsurance</u>	30% <u>coinsurance</u>	100 visits/benefit period.
	<u>Rehabilitation services</u>	\$20/visit	30% <u>coinsurance</u>	*See Therapy Services section
	<u>Habilitation services</u>	\$20/visit	30% <u>coinsurance</u>	100 day limit/ stay.
If you need help recovering or have other special health needs	<u>Skilled nursing care</u>	See Inpatient	30% <u>coinsurance</u>	-----none-----
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	Children's eye exam	\$0	Amount above \$30 reimbursement	*See Vision Services section
	Children's glasses	Not covered	Not covered	
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	*See Dental Services section

### Excluded Services & Other Covered Services:

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

• Acupuncture	• Bariatric surgery	• Cosmetic surgery
• Dental care (adult)	• Dental Check-up	• Glasses for a child
• Hearing aids	• Infertility treatment	• Long-term care
• Routine foot care unless you have been diagnosed with diabetes.	• Weight loss programs	

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

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

• Abortion	• Chiropractic care 30 visits/benefit period.	• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a>
• Private-duty nursing Outpatient services limited to 16 hours per member per calendar year.	• Routine eye care (adult) Coverage is limited to 1 <a href="#">screening exam</a>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279  
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)  
Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

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

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

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

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

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

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.



About these Coverage Examples:



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

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$300
- Other copayment \$20

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

Total Example Cost	\$12,840
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$300
- Other copayment \$20

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

Total Example Cost	\$7,460
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$2,555

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment \$300
- Other copayment \$20

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

Total Example Cost	\$2,010
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,440
<u>Coinsurance</u>	\$15
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,455

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/fi>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$1,350</b> /single or <b>\$2,700</b> /family for In- <a href="#">Network Providers</a> . <b>\$1,350</b> /single or <b>\$2,700</b> /family for Non- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay. Deductibles are non-embedded.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and Vision exam for In- <a href="#">Network Providers</a> . Also PreventiveRX.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$5,000</b> /single or <b>\$10,000</b> /family for In- <a href="#">Network Providers</a> . <b>\$10,000</b> /single or <b>\$20,000</b> /family for Non- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met. OOP maximums are non-embedded.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Pre-Authorization Penalties, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, KeyCare. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 333-5735 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Tier 1 - Typically Generic	\$10 copay (retail and home delivery)	40% <a href="#">coinsurance</a> (retail and home delivery)	*See Prescription Drug section. Medications included on Anthem's Preventive RX list are covered at 100% and the deductible does not apply.
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	\$30 copay (retail) / \$60 copay home delivery)	40% <a href="#">coinsurance</a> (retail and home delivery)	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$50 copay (retail) / \$150 copay home delivery)	40% <a href="#">coinsurance</a> (retail and home delivery)	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	\$50 copay (retail and home delivery)	40% <a href="#">coinsurance</a> (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/ surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	Emergency medical transportation	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/ surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health,	Outpatient services	Office Visit	Office Visit	Office Visit
		20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
		Other Outpatient	Other Outpatient	Other Outpatient
		20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
or substance abuse services	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 visits/benefit period.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	*See Therapy Services section
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 day limit/ stay.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	\$0/visit deductible does not apply	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	*See Dental Services section
	Children's dental check-up	Not covered	Not covered	

#### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded</u> services.)	
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care (adult)</li> <li>• Hearing aids</li> <li>• Routine foot care unless you have been diagnosed with diabetes.</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental Check-up</li> <li>• Infertility treatment</li> <li>• Weight loss programs</li> <li>• Cosmetic surgery</li> <li>• Glasses for a child</li> <li>• Long- term care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Private-duty nursing Outpatient services limited to 16 hours per member per calendar year.</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care 30 visits/benefit period.</li> <li>• Routine eye care (adult) Coverage is limited to 1 <u>screening exam</u></li> <li>• Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcare.com">www.bcbsglobalcare.com</a></li> </ul>

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



**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

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

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

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

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

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

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

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

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

About these Coverage Examples:



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

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

- The plan's overall deductible **\$1,350**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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

Total Example Cost	\$12,840
--------------------	----------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$2,225
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,635

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

- The plan's overall deductible **\$1,350**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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

Total Example Cost	\$7,460
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,350
Copayments	\$1,250
Coinsurance	\$337
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$2,992

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

- The plan's overall deductible **\$1,350**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **20%**

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

Total Example Cost	\$2,010
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,350
Copayments	\$0
Coinsurance	\$535
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,885

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

# Your summary of benefits

Anthem Blue Cross and Blue Shield

Your Contract Code: Custom

Your Plan: Custom Anthem KeyCare Plus 20/20%/2500

Your Network: KeyCare PPO

*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 to the applicable Anthem enrollment brochure.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$0 person / \$0 family	\$750 person / \$1,500 family
<b>Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$2,500 person / \$5,000 family	\$3,750 person / \$7,500 family
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	Covered in Full	30% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>  <b>Primary care visit to treat an injury or illness</b>	\$20 copay per visit	30% coinsurance after deductible is met
<b>Specialist care visit</b>	\$40 copay per visit	30% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	\$300 copay per pregnancy	30% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Other practitioner visits:</b> Retail health clinic  On-line Medical Visit <i>Live Health Online is the preferred telehealth solutions</i> <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> Chiropractic services <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.</i>	\$20 copay per visit  \$10 copay per visit  \$20 copay per visit	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Other services in an office:</b> Allergy testing  Chemo/radiation therapy  Dialysis/Hemodialysis  Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection.</i>	\$20 copay per visit  20% coinsurance  20% coinsurance  20% coinsurance	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<b>Diagnostic Services</b> <b>Lab:</b> Office  Preferred Reference Lab  Outpatient Hospital	20% coinsurance  Covered in Full  \$300 copay per visit	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>X-ray:</b> Office  Freestanding Radiology Center  Outpatient Hospital	20% coinsurance  \$300 copay per visit  \$300 copay per visit	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b> Office  Freestanding Radiology Center  Outpatient Hospital	20% coinsurance  \$300 copay per visit  \$300 copay per visit	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Emergency and Urgent Care</b> <b>Emergency room facility services</b>  <b>Emergency room doctor and other services</b>	\$250 copay per visit  20% coinsurance	Covered as In-Network  Covered as In-Network
<b>Ambulance Transportation</b>	20% coinsurance	Covered as In-Network
<b>Urgent Care Center Office Visit</b>	\$40 copay per visit	30% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Outpatient Mental Health and Substance Use Disorder</b> <b>Doctor office visit and Online Visit</b>  <b>Facility visit:</b> Facility fees  Doctor Services	\$20 copay per visit  \$200 copay per visit  \$20 copay per visit	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Outpatient Surgery</b> <b>Facility fees:</b> Hospital  Freestanding Surgical Center  <b>Doctor and other services</b> Surgery	\$300 copay per visit  \$300 copay per visit  \$40 copay per visit	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)</b> <b>Facility fees (for example, room &amp; board)</b>  <b>Doctor and other services</b>	\$300 copay per day up to 5 days per admission  \$40 copay per visit	30% coinsurance after deductible is met  30% coinsurance after deductible is met

## Your summary of benefits

[illegible]



## Your summary of benefits

<b>Habilitation services (for example, physical/speech/occupational therapy):</b>  Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i>  Outpatient hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i>	\$20 copay per visit	30% coinsurance after deductible is met
	20% coinsurance	30% coinsurance after deductible is met
<b>Cardiac rehabilitation</b>  Office Visit   Outpatient hospital	\$40 copay per visit   20% coinsurance	30% coinsurance after deductible is met   30% coinsurance after deductible is met
<b>Skilled nursing care (in a facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per admission.</i>	\$300 copay per day up to 5 days per admission	30% coinsurance after deductible is met
<b>Hospice</b>	20% coinsurance	30% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance	30% coinsurance after deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.</i>	20% coinsurance	30% coinsurance after deductible is met



# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Not Applicable	Not Applicable
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Combined with medical out of pocket
<b>Prescription Drug Coverage</b> <i>Anthem National Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>  <i>To view the medication listing for this benefit plan option, please visit <a href="https://www.anthem.com/pharmacyinformation/">https://www.anthem.com/pharmacyinformation/</a> and scroll down to National Drug List section. Click on "National List 4 Tier Searchable" link or "Virginia PDF link" on the same 4 tier line.</i>		
<b>Tier 1 - Typically Generic</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i>	\$10 copay per prescription (retail only). \$10 copay per prescription (home delivery only).	30% coinsurance (retail and home delivery).
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i>	\$30 copay per prescription (retail only). \$60 copay per prescription (home delivery only).	30% coinsurance (retail and home delivery).

# Your summary of benefits

<b>Tier 3 - Typically Non-Preferred Brand</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i>	\$50 copay per prescription (retail only). \$150 copay per prescription (home delivery only).	30% coinsurance (retail and home delivery).
<b>Tier 4 - Typically Preferred Specialty (brand and generic)</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 30 day supply (home delivery program.) Note: Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. No coverage for non-formulary drugs.</i>	\$50 (retail and home delivery).	30% coinsurance (retail and home delivery).
Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.</i>		
<b>Child Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>	Covered in Full	\$30 reimbursement
<b>Adult Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>	\$15 copay per visit	\$30 reimbursement

# Your summary of benefits

## Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- For additional information on this plan, please visit [sbc.anthem.com](http://sbc.anthem.com) to obtain a "Summary of Benefit Coverage".
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- In-network preventive care is not subject to deductible, if your plan has a deductible
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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Questions: Visit us at [www.anthem.com](http://www.anthem.com)

VA/L/Anthem KeyCare Plus 20/20%/4000/398X/01-18

### 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 (844) 682-6553.

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# Your summary of benefits

Anthem Blue Cross and Blue Shield

Your Contract Code: Custom

Your Plan: Custom Anthem HDHP\_HSA w/\$1350 Deductible

Your Network: KeyCare PPO

*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 to the applicable Anthem enrollment brochure.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$1,350 person / \$2,700 family	\$1,350 person / \$2,700 family
<b>Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$5,000 person / \$10,000 family	\$10,000 person / \$20,000 family
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible. <b><u>Also includes medications considered by Anthem to be Preventive.</u></b></i>	Covered in Full	40% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>  <b>Primary care visit to treat an injury or illness</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Specialist care visit</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met



# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Other practitioner visits:</b> Retail health clinic  On-line Medical Visit <i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</i> Chiropractic services <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.</i>	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
<b>Other services in an office:</b> Allergy testing  Chemo/radiation therapy  Dialysis/Hemodialysis  Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection]</i>	20% coinsurance after deductible is met 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 40% coinsurance after deductible is met
<b>Diagnostic Services</b> <b>Lab:</b> Office  Preferred 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

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>X-ray:</b> Office  Freestanding Radiology Center  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
<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b> Office  Freestanding Radiology Center  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
<b>Emergency and Urgent Care</b> <b>Emergency room facility services</b>  <b>Emergency room doctor and other services</b>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	Covered as In-Network  Covered as In-Network
<b>Ambulance Transportation</b>	20% coinsurance after deductible is met	Covered as In-Network
<b>Urgent Care Center Office Visit</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met



# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Outpatient Mental Health and Substance Use Disorder</b>  <b>Doctor Office Visit and Online Visit</b>  <b>Facility visit:</b> Facility fees  Doctor Services	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
<b>Outpatient Surgery</b> <b>Facility fees:</b> Hospital  Freestanding Surgical Center  <b>Doctor and other services</b> 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
<b>Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)</b>  <b>Facility fees (for example, room &amp; board)</b>  <b>Doctor and other services</b>	20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Recovery &amp; Rehabilitation</b>  <b>Home health care</b> <i>Coverage for In-Network and Non-Network Provider combined is limited to 100 visits per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Rehabilitation services (for example, physical/speech/occupational therapy):</b>  <b>Office</b> <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i>  <b>Outpatient hospital</b> <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Habilitation services (for example, physical/speech/occupational therapy):</b>  <b>Office</b> <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i>  <b>Outpatient hospital</b> <i>Coverage for rehabilitative and habilitative physical therapy and</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i>	met	met
<b>Cardiac rehabilitation</b> Office Visit  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
<b>Skilled nursing care (in a facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 100 days per admission.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Hospice</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to 1 unit per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Combined with medical out of pocket
<b>Prescription Drug Coverage</b> <i>Anthem National Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>  <i>To view the medication listing for this benefit plan option, please visit <a href="https://www.anthem.com/pharmacyinformation/">https://www.anthem.com/pharmacyinformation/</a> and scroll down to National Drug List section. Click on "National List 4 Tier Searchable" link or "Virginia PDF link" on the same 4 tier line.</i>		
<b>Preventive RX</b> <i>See Anthem benefit materials for additional information</i>	Covered in Full; deductible does not apply	40% coinsurance after deductible is met
<b>Tier 1 - Typically Generic</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i>	After deductible is met(retail and home delivery):  \$10 copay per prescription (retail only). \$10 copay per prescription (home delivery only).	40% coinsurance after deductible is met(retail and home delivery).
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i>	After deductible is met(retail and home delivery):  \$30 copay per prescription (retail only). \$60 copay per prescription (home delivery only).	40% coinsurance after deductible is met(retail and home delivery).

# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.) No coverage for non-formulary drugs. Note: A 90 day supply is available at retail maintenance pharmacies with a copay for each 30 day supply. Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time.</i>	After deductible is met(retail and home delivery):  \$50 copay per prescription (retail only). \$150 copay per prescription (home delivery only).	40% coinsurance after deductible is met(retail and home delivery).
<b>Tier 4 - Typically Preferred Specialty (brand and generic)</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 30 day supply (home delivery program.) Note: Coverage is also provided at retail for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. No coverage for non-formulary drugs.</i>	After deductible is met(retail and home delivery):  \$50 (retail and home delivery).	40% coinsurance after deductible is met(retail and home delivery).
Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail.</i>		
<b>Child Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>	No charge	\$30 reimbursement
<b>Adult Vision exam</b> <i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>	\$15 copay per visit	\$30 reimbursement

# Your summary of benefits

## Notes:

- The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage
- Your coinsurance, copays and deductible count toward your out of pocket amount.
- For additional information on this plan, please visit [sbc.anthem.com](http://sbc.anthem.com) to obtain a "Summary of Benefit Coverage".
- All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- In-network preventive care is not subject to deductible, if your plan has a deductible
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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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 (844) 682-6553 로 문의하십시오.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ní nizaad k'ehǫ́ bee níí hodoonih t'áadoo bǫ́áh ilínígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínizingo koǫ́ hodiílnih (844) 682-6553.

## 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: (844) 682-6553.

**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, (844) 682-6553 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. (844) 682-6553.

**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 (844) 682-6553.

**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 (844) 682-6553.

**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 (844) 682-6553.

### It's important we treat you fairly

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



# Take care of yourself

## Use your preventive care benefits

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

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

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

### Preventive vs. diagnostic care

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

### Adult preventive care

#### Preventive physical exams

##### Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)<sup>3</sup>
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening\*
- Eye chart test for vision<sup>2</sup>
- Hearing screening
- Height, weight and body mass index (BMI)
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years<sup>3</sup>
- Obesity: related screening and counseling\*
- Prostate cancer, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening
- Violence, interpersonal and domestic: related screening and counseling

##### Immunizations:

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

##### Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met<sup>4</sup>
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling<sup>5,6,7</sup>
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression<sup>6</sup>
- Pelvic exam and Pap test, including screening for cervical cancer

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

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

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

## Child preventive care

### Preventive physical exams

#### Screening tests:

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

#### Immunizations:

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

## A word about pharmacy items

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

- Meet certain age requirements and other rules.
- Get prescriptions from plan providers and fill them at plan pharmacies.
- Have prescriptions, even for OTC items.

### Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease, preeclampsia and colorectal cancer by adults less than 70 years old.
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Generic low to moderate dose statins for members that are 40-75 years and have 1 or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Tobacco-cessation products, including all FDA-approved brand and generic OTC and prescription products, for those ages 18 and older

### Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent the tooth decay of primary teeth for children ages 0-5
- Fluoride supplements for children ages 6 months to 16 years old

### Women's preventive drugs and other pharmacy items — age appropriate:

- Contraceptives, including generic prescription drugs, brand-name drugs with no generic equivalent and OTC items like female condoms and spermicides<sup>6,8,9</sup>
- Low-dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women ages 55 or younger who are planning and able to get pregnant

Breast cancer risk-reducing medications, such as tamoxifen and raloxifene, that follow the U.S. Preventive Services Task Force criteria<sup>3</sup>

**For a complete list of covered preventive drugs under the Affordable Care Act, view the Preventive ACA Drug List flier available at [anthem.com/pharmacyinformation](http://anthem.com/pharmacyinformation).**

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

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

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

4 Check your medical policy for details.

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

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

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

8 A cost share may apply for other prescription contraceptives, based on your drug benefits.

9 Your cost share may be waived if your doctor decides that using the multisource brand is medically necessary.

### Welcome to your Blue View Vision plan!

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

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

### USING YOUR BLUE VIEW VISION PLAN

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

### ADDITIONAL SAVINGS ON EYEWEAR AND MORE

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

### OUT-OF-NETWORK

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

**To Fax:** 866-293-7373  
**To Email:** [oonclaims@eyewearspecialoffers.com](mailto:oonclaims@eyewearspecialoffers.com)  
**To Mail:** Blue View Vision  
 Attn: OON Claims  
 P.O. Box 8504  
 Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit [anthem.com](http://anthem.com) or call us at the number on the back of your ID card.

This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		Member Pays
<b>Retinal Imaging</b>	<ul style="list-style-type: none"> <li>At member's option can be performed at time of eye exam</li> </ul>	Not more than \$39
<b>Eyeglass Frame</b>	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*</li> </ul>	35% off retail price
<b>Eyeglass Lenses</b> Standard plastic material	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*:               <ul style="list-style-type: none"> <li>Single Vision \$50</li> <li>Bifocal \$70</li> <li>Trifocal \$105</li> </ul> </li> </ul>	
<b>Eyeglass Lens Options and Upgrades</b> When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*:               <ul style="list-style-type: none"> <li>UV Coating \$15</li> <li>Tint (Solid and Gradient) \$15</li> <li>Standard Scratch-Resistant Coating \$15</li> <li>Standard Polycarbonate \$40</li> <li>Standard Anti-Reflective Coating \$45</li> <li>Standard Progressive Lenses (add-on to Bifocal) \$65</li> <li>Other Add-Ons 20% off retail price</li> </ul> </li> </ul>	
<b>Conventional Contact Lenses</b> (non-disposable type)	<ul style="list-style-type: none"> <li>Discount applies to materials only</li> </ul>	15% off retail price

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

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

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



#### ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

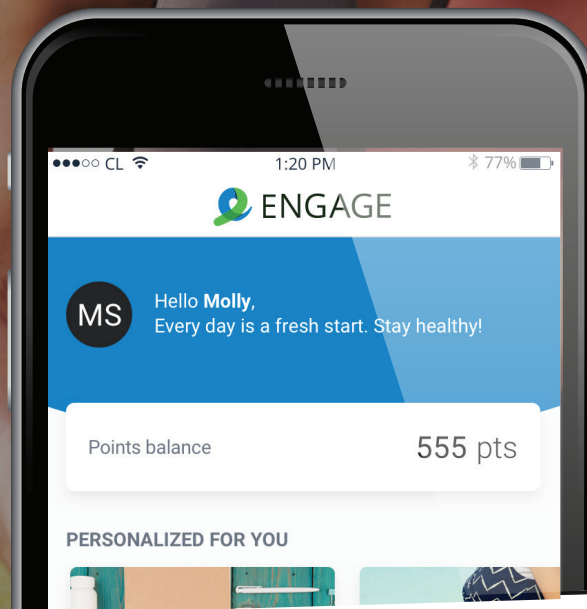
Other savings offers are available on eyewear, hearing aids and even LASIK laser vision correction surgery through a variety of vendors. Just **log in at anthem.com**, select discounts, then Vision, Hearing & Dental.

# Meet Engage, your personalized health assistant

Engage helps you make the most of your health plan and connect with resources to achieve your wellness goals.

Download the

Engage Wellbeing App today!



## Get peace of mind.

Clearly see what's covered by your plan and access your digital insurance card anytime, anywhere.



## Take charge of your wellness.

Track sleep, steps and food to create healthy habits and hit your well being goals.



## Make the most of your perks.

Save time and money by discovering additional benefits and programs.

Anthem.  
BlueCross BlueShield





# Built for the real world. *All for you.*

Simplify your health care experience with a personalized health assistant that connects you to the right benefits and programs at the right time. With Engage, you can:



See all of your medical and pharmacy benefits in one place.



Access LiveHealth Online and have face-to-face video visit with a doctor/therapist on your smartphone, computer or mobile device.



Learn more about our health and wellness programs, like 24/7 NurseLine, Condition Care and Future Moms.



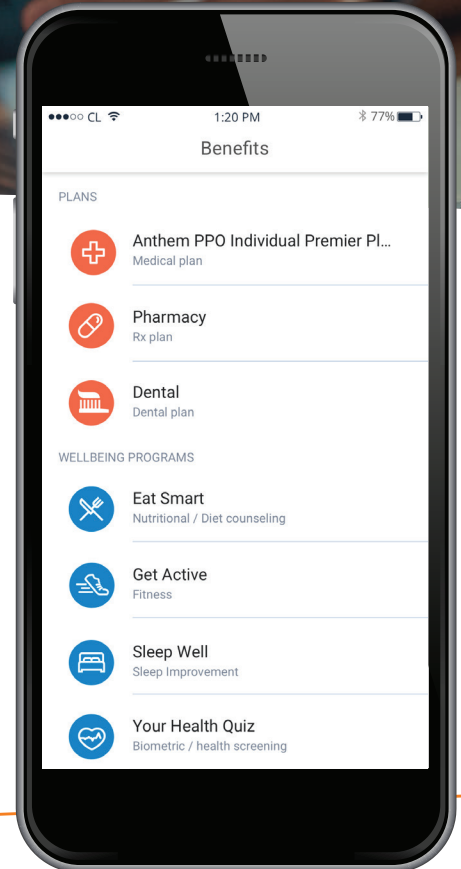
Participate in well-being challenges to help keep you active and healthy



Sync fitness and wellness data with your wearable fitness device.



Protect yourself from overpaying by seeing the cost of services and care **before** setting up a visit.



Using Engage, you can get support through a mobile device, computer or phone.

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

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](http://anthem.com/co/networkaccess). In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In 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 Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield of Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) 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.



# LiveHealth Online

Quick and easy access  
to a doctor 24/7



Have you ever been at work and didn't feel well? Maybe you had a fever or a sore throat but you didn't have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It's so convenient, almost 90% of people who've used it feel they saved two hours or more and would use it again in the future.<sup>1</sup> Plus, online visits using LiveHealth Online are already part of your Anthem Blue Cross and Blue Shield benefits. To start using LiveHealth Online, all you need to do is sign up at [livehealthonline.com](https://livehealthonline.com) or download the app.

## Sign up for free today and get:

1. **24/7 access to doctors.** They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed.<sup>2</sup> It's a great way to get care when your doctor isn't available.
2. **Medical care when you need it.** For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.
3. **Convenience.** Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less.

Doctors using LiveHealth Online typically charge \$49 or less per visit, depending on your health plan.

## LiveHealth Online Psychology

An easy, convenient way to see a therapist or psychologist in just a few days

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It's easy to use, private and, in most cases, you can see a therapist within four days or less.<sup>3</sup> All you have to do is sign up at [livehealthonline.com](https://livehealthonline.com) or download the app to get started. The cost is similar to what you'd pay for an office therapy visit.

## Make your first appointment — when it's easy for you

- Use the app or go to [livehealthonline.com](https://livehealthonline.com) and log in. Select **LiveHealth Online Psychology** and choose the therapist you'd like to see.
- Or, call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m.
- You'll get an email confirming your appointment.



BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

**LiveHealth**  
O N L I N E

## LiveHealth Online: what you need to know

### What kind of doctors can you see on LiveHealth Online?

Doctors on LiveHealth Online are:

- Board certified with an average of 15 years of practicing medicine
- Mainly primary care physicians
- Specially trained for online visits

### When can you use LiveHealth Online?

LiveHealth Online is a great option for care when your own doctor isn't available and more convenient than a trip to the urgent care. With LiveHealth Online, you can receive medical care for things like:

- Cold and flu symptoms, such as a cough, fever and headaches
- Allergies
- Sinus infections and more

### How do I pay for an online visit using LiveHealth Online?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online doctor visit. Keep in mind that charges for prescriptions aren't included in the cost of your doctor visit.

## LiveHealth Online Psychology

### What conditions can be treated when you have a visit with a psychologist or therapist?

You can get help for these types of conditions:

- Stress
- Anxiety
- Depression
- Family or relationship issues
- Grief
- Panic attacks
- Stress from coping with a sickness



### How much does a therapist visit cost?

The cost should be similar to what you'd pay for an office therapy visit, depending on your benefits, copay or coinsurance. You'll see what you owe before you start a visit and any cost is charged to your credit card. The cost is the same no matter when you have the visit — whether it's a weekday, the weekend, evening or a holiday.

### How do I decide which therapist to see?

After you log in at [livehealthonline.com](https://livehealthonline.com) or with the app, select **LiveHealth Online Psychology**. Next, you can read profiles of therapists and psychologists. Once you select the one you would like to see, schedule a visit online or by phone. At the end of the first visit, you can set up future visits with the same therapist if both of you feel it's needed. You always have the choice of the therapist you want to see.

### What else do I need to know about LiveHealth Online Psychology?

- You must be at least 18 years old to see a therapist online and have your own LiveHealth Online account.
- Psychologists and therapists using LiveHealth Online do not prescribe medications.
- Visits usually last about 45 minutes.

## Get started today

It's quick and easy to sign up for LiveHealth Online. Just go to [livehealthonline.com](https://livehealthonline.com) or download the mobile app at [Google Play™](https://play.google.com/store/apps/details?id=com.livehealthonline) or the [App Store<sup>SM</sup>](https://apps.apple.com/us/app/livehealth-online/id1450454444).

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

1 LiveHealth Online user feedback survey, May 2015.

2 Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to grow more in the near future. Please visit the map at [livehealthonline.com](https://livehealthonline.com) for more details.

3 Appointments subject to availability of a therapist.

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# The savvy member's action guide

## Smart ways Anthem members get more from their health plans

### Sometimes the simple things make a big difference

Here are a few easy tips you can use to get more from your benefits and save money on health care. You can find more detailed information on these tips at [anthem.com](https://www.anthem.com).

#### Savvy ways to keep overall costs down

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

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

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

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

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

##### Tip #2: Estimate your Cost

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

##### How to get an estimate of costs:

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



### Tip #3: Keep an eye on your EOB

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

### Tip #4: Use network doctors and hospitals

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

Three quick ways to find network care:

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

## Savvy places to get quality care at lower costs

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

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

### Tip #2: Ask about your options for radiology services

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

### Tip #3: Use freestanding labs

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

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

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





## Savvy choices in preventive care and wellness programs

### Tip #1: Get preventive care

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

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

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

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

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



## Savvy savings on prescriptions

### Tip #1: Shop around for the lowest drug costs

You can buy your prescription drugs from different places: local pharmacies, retailers, grocery stores and home delivery pharmacy. Drug prices can vary quite a bit from place to place. You can save money by comparing costs before you fill your prescription.

### Tip #2: Choose generic drugs

Generic drugs generally work just as well as brand-name drugs, but cost much less. The Food and Drug Administration (FDA) requires that brand and generic drugs have the same active ingredients, strength and dose. Ask your doctor if generics are available and right for you. If not, your doctor may know of other brand names that cost less.

### Tip #3: Use over-the-counter drugs when you can

You don't need a prescription for over-the-counter (OTC) drugs. They often have the same active ingredients as some prescription drugs, but usually cost a lot less. OTC allergy and heartburn medicines are good examples. Just make sure to ask your doctor if it's okay to swap your prescription drug for an OTC medicine.

### Tip #4: Look into our special pharmacy programs

We have two programs that can help you save right away by lowering your copay or coinsurance. Call the pharmacy number on your Anthem ID card to see if you qualify for these programs. Then, ask your doctor if one could be right for you:

- Use our Half Tablet program to save money without changing drugs. You get your current medicine on the Half Tablet program drug list prescribed at double the strength, then use a tablet splitter to cut the tablet in half. You can save up to 50% off your typical copay with this program.
- Use our GenericSelect program the first time you fill a new prescription by filling it with a generic on our list. We'll waive your first copay at a retail pharmacy or our home delivery pharmacy.

## Register today at [anthem.com](https://www.anthem.com)

Explore and sign up on our members-only site to learn more about your health care options, costs and ways to help take control of your health. You can also call Member Services for help.





# Your healthy weight resource center

Start your weight  
management journey  
with us.

## The Weight Center can guide you in the right direction

We know keeping a healthy weight can be a struggle — especially when life gets busy. And it's about feeling good, not just a number on a scale. Weight issues put you at greater risk for serious health conditions, like heart disease and diabetes, and can affect your quality of life.

That's why Anthem Blue Cross and Blue Shield is proud to introduce *The Weight Center*, a dedicated page on [anthem.com](http://anthem.com) that houses lots of no-cost resources and information to help you manage your weight.

### The Weight Center includes:

- An interactive and printable *Weight Management Playbook*, with sections on "Fitness," "Nutrition" and "Well-being"
- A list of eligible weight management programs
- WebMD<sup>®</sup> tips on getting active, healthy eating, improving your sleep and energy levels, and reducing stress
- SpecialOffers discounts on fitness and health items, such as Garmin fitness devices
- A link to a fun, upbeat Health Heroes radio station at Pandora<sup>®</sup> for motivational workout tunes
- A body mass index (BMI) calculator to measure your body fat based on height and weight

### How do I get to The Weight Center page?

1. Go to [anthem.com/theweightcenter](http://anthem.com/theweightcenter).
2. Log in or register.
3. Browse topics of interest.

Whether you're at your ideal weight and want to maintain or have pounds to shed or gain, you can find the guidance you need to meet your goals. Plus, as part of our whole health approach, we can offer you recommendations for programs that address your unique health concerns.

Health and wellness programs are not covered services under the health plan, but are additions; these programs' features are not guaranteed under your health plan certificate and could be discontinued at any time. Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

## We're required by law to provide you with the following information:

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 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.

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
•			<b>Your employer:</b> <ul style="list-style-type: none"> <li>• Keeps its status as an employer.</li> <li>• Stays in our service area.</li> <li>• Meets our guidelines for employee participation and premium contribution.</li> <li>• Pays the required health care premiums.</li> <li>• Doesn't commit fraud or misrepresent itself.</li> </ul>
	•		<b>Your employer:</b> <ul style="list-style-type: none"> <li>• Makes a bad payment.</li> <li>• Voluntarily cancels coverage (30-days advance written notice required).</li> <li>• Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan.</li> <li>• Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).</li> </ul>
	•		<ul style="list-style-type: none"> <li>• We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice).</li> <li>• We decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).</li> </ul>
		•	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"> <li>• Stay eligible for your employer's coverage.</li> <li>• Pay your share of the monthly payment (premium) for coverage.</li> <li>• Don't commit fraud or misrepresent yourself.</li> </ul>
	•	<b>Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.</b>
	•	<ul style="list-style-type: none"> <li>• Lose your eligibility for coverage.</li> <li>• Don't make required payments or make bad payments.</li> <li>• Commit fraud.</li> <li>• Are guilty of gross misbehavior.</li> <li>• Don't cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries).</li> <li>• Let others use your ID card.</li> <li>• Use another member's ID card.</li> <li>• File false claims with us.</li> </ul> <b>Your coverage will be canceled after you receive a written notice from us.</b>

## Special enrollment period

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.

Factors used to set the price of health care coverage for employers with 51-99 employees (these factors don't apply to groups with 100 or more full time employees):

- The plan selected by your employer
- Your employer's location
- The age and gender of each employee
- The number of enrolled employees
- The number of dependents enrolled by each enrollee
- The health status of the enrolled employees and their dependents
- Your employer's history

### 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 cost.

## Determining the primary and secondary plans

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

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

## How benefits apply if you're eligible for Medicare

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

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

## Recovering overpayments.

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

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

## What's not covered

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

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

**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, see 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.

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

- Acupuncture
- 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
- Electromagnetic therapy
- Neurofeedback / Biofeedback

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

**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), physical therapist technicians, and athletic trainers.



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

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

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

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

**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.

The following Contraceptives exclusion only pertains to groups that qualify to opt out:

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

**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.

**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 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 us.

**Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

**Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

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

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

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

Please see the "Clinical Trials" section of "What's Covered" of your post enrollment Evidence of Coverage or Member Booklet 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.

**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 for patients with diabetes or vascular disease.

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

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

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

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

**Gene Therapy** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

**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** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

#### Home 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.

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

**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 when you became eligible due to age, 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 become eligible due to age, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

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

**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 it by law or if we approve it.

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

#### Personal Care and Convenience

- 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,
- Hypo-allergenic pillows, mattresses, or waterbeds,
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

**Private Duty Nursing** Private Duty Nursing Services, unless listed as covered in this Booklet. Your coverage does not include benefits for private duty nurses in the inpatient setting.

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

**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.
- Wilderness camps.

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



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

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

The following Sterilization exclusion does not apply to groups that qualify to opt out:

**Sterilization** Services to reverse elective sterilization.

**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).

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

**Temporomandibular Joint Treatment** Fixed or removable appliances which 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.

#### Vision Services

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

**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.

**Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

## 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 us or the PBM.

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

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

The following exclusion does not apply to groups that qualify to opt out:

**Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law.

**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](http://www.anthem.com). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.

**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 us.

**Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

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

**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.

**Gene Therapy** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

**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 blood glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.

**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 of the post enrollment Evidence of Coverage or Member Booklet 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.

**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 of the post enrollment Evidence of Coverage or Member Booklet.

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 immune-compromised or diabetic.

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

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

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

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

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

These policies have exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for Anthem HealthKeepers and POS AdvantageOne plans: AHK-VA-HMOPOS-FIMC (2/17), AHK-VA-LG-HMOPOS-EOC (1/18), AHK-ABCBS-VA-PAP-FIMC, AHK-ABCBS-VA-LG-PAP-EOC (1/18). For KeyCare plans: KeyCare, Lumenos or POS AdvantageOne plans: ABCBS-VA-PPO-FIMC (2/17), ABCBS-VA-LG-PPO-COC (1/18), AHK-ABCBS-VA-PAP-FIMC, AHK-ABCBS-VA-LG-PAP-EOC (1/18)

If you have questions, please contact your agent, Group Administrator, or member services: Enrollment applications used for these plans: LG\_51-99\_EE\_VA 7/18 and LG\_100+\_EE\_VA 7/18. This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. or by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern.



# Let's talk about your privacy and rights

## Safeguarding your information

As a member, you have the right to expect us to protect the privacy of your personal health information. We do this according to state and federal laws, and our policies. You also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to [anthem.com/memberrights](https://www.anthem.com/memberrights). To ask for a printed copy, please contact your Benefits Administrator or Human Resources representative.

### How we help manage your care

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

To learn more detailed information about how we help manage your care, visit [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 enroll in a plan or make changes to it. If you choose not to enroll yourself or dependents during open enrollment, there are special cases when you're allowed to enroll yourself and dependents in a plan during other times of the year. Special enrollment is allowed:

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

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

- **If you have a new dependent.** You gain new dependents from a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes.** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or SCHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.



## This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.





# We've got your back!



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

These policies have exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: Group Policy GP-1 (7/02), GP-TOC, GP-ELIG (10/17) and GP-GEN (10/17), PP-INTRO (10/17), P-TOC (1/15), P-SB6 (10/17), P-WORKS (10/17), P-COVERED (10/17), P-EXCL (10/17), P-CLAIMS (10/17), P-COB (1/16), P-ENR (10/17), P-ENDS (1/17), P-INFO (1/17), P-RIGHTS (1/17), P-DEF (10/17), P-EXH-A (1/17), P-INDEX (7/10). Enrollment application used for these plans: 490773 (10/17), 490773 (7/15). This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area. Life and Disability products underwritten by Anthem Life Insurance Company. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

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