Choosing and using your plan

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

PPO Plan 4, PPO Plan 7 HSA and HMO Plan 9 POS Open Access

Virginia Private Colleges Benefits Consortium: Roanoke College

Effective January 1, 2023

Anthem

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

Time to choose your plan

Your trusted health partner

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

Time to choose your plan

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

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

This guide was created to help you understand our plans. It also has tips, tools, and resources that can help you reach your health and wellness goals when you become a member. Save it to help you make the most of your benefits throughout the year.

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Explore your plan options

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

PPO

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

- You can choose a primary care doctor from the plan's network for preventive care such as checkups and screenings.
- You do not need to have a primary care doctor to see a specialist.
- When you want to see a specialist, such as an orthopedic doctor or a cardiologist, you do not need to visit your primary care doctor first for a referral. This can save you time and a copay.
- Choosing doctors and facilities in your plan's network — instead of those outside your plan's network — helps lower your costs.

HMO

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

- If you need care from a specialist, such as an orthopedic doctor or a cardiologist, you don't need to visit your PCP first to get a referral. This can save you time and a copay.

Explore your plan options

Health savings account (HSA)

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

- Once you pay your deductible, you will pay a percentage of the total cost (called coinsurance) anytime you receive care for a covered service. Your plan will cover the rest.
- All the money in your HSA rolls over from year to year, and it is yours even if you change health plans or jobs, or retire.
- The money you put into your HSA, any interest you earn, and the money you take out to pay for healthcare is tax-free.
- You can contribute up to $3,850 for an individual and $7,750 for a family.[2]
- If you are 55 or older, you can contribute an extra $1,000 a year.

How to choose a plan

- Think about your personal situation. Have your healthcare needs changed? Do you go to the doctor more often now? Are you taking a special prescription drug? Do you have any upcoming surgeries? You will want to look for benefits that fit your needs.
- Compare all the costs, including your monthly payment, deductible, coinsurance, copay, and out-of-pocket limit.
- Find out if your doctors, hospitals, and healthcare professionals are covered by the plan.
- Choose the right plan for your needs.

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

Pharmacy Benefits

What your plan will cover

Your medication coverage

Your plan covers:

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

Your drug list

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

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

To find the latest drug lists:

- Visit **anthem.com/nationaldirect4tierva** for the **VA 4 Tier** Drug List.

Your pharmacy options

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

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

How your pharmacy benefits work

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

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

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

Using your plan

How to use your plan

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

How to use your plan

Register for online tools and resources

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

Sydney Health mobile app

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

Working with you:

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

Working for you:

- **Virtual chat visits** — **Sydney Health** can link you directly to doctors for virtual chat visits at no extra cost.* During your appointment; the doctor will evaluate your symptoms; discuss your treatment options, and order prescriptions, if you need them.
- **Virtual video visits** — You can also use **Sydney Health** to connect with a doctor through video visits.
- **Virtual primary care** — When you need preventive care, such as wellness check-ins, lab work referrals, new prescriptions or refills, specialist referrals, or help with a long-term condition such as asthma, you can use Sydney Health to have a video visit with a doctor.

The Anthem Skill — The Anthem Skill for Alexa is a voice-activated assistant for your health plan. Receive answers to your healthcare questions — hands-free by enabling the Anthem Skill. It works through any Alexa-enabled device, such as an Amazon Echo, or on your mobile device using the Amazon Alexa app. If you do not have the Amazon Alexa app, download it from Google Play™ or the App Store®.

- Ask for your digital member ID card.
- Check your progress toward meeting your medical plan's deductible and out-of-pocket maximum.
- Refill, renew, and check the order status of any home-delivery prescriptions.

* Pricing based on $0 copay benefit eligibility offered through your plan.

How to use your plan

Use your ID card from your phone

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

Find a doctor in your plan

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

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

Schedule a checkup

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

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

Receive the COVID-19 vaccine or booster shot at no extra cost

A COVID-19 vaccine can help keep you, your family, and your community safe. You and your covered family members will not have to pay out-of-pocket costs for COVID-19 vaccine or booster doses. Your Anthem plan covers them.

You can visit any healthcare professional for your vaccine or booster shot, including those outside your plan's network.

Go to vaccines.gov to find COVID-19 vaccine locations near you.

How to use your plan

Access care from home in a way that works for you

- **Assess your symptoms online at no cost**. Answer questions through the **Sydney Health** intuitive Symptom Checker. It uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you visit a doctor.
- **Chat with a doctor at no extra cost.**[1] **Sydney Health** can link you directly to doctors for virtual chat visits. During your appointment, the doctor can evaluate your symptoms; discuss your treatment options; and order prescriptions; if you need them.
- **Have a video visit with a doctor**. You can also use **Sydney Health** to connect with a doctor through video visits.
- **Schedule a virtual primary care appointment** for routine care and prescription refills, if needed. You can also receive a personalized care plan for chronic conditions, such as heart disease.

Where to go for care when you need it now

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

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care to avoid costly emergency room visits and long wait times.
- See a doctor anytime using LiveHealth Online from your mobile device or computer.

1 If you have a high-deductible health plan and have not met your deductible, the price of a visit will be $39, starting on the date in 2022 your plan renews.

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

Make the most of your pharmacy benefits

Understanding medicine coverage and costs

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

Coverage requirements

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

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

You have pharmacy options

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

Your plan uses the **Base Network** list of pharmacies.
The **Base Network** is our national pharmacy network and includes nearly 67,000 retail pharmacies across the country. To find a pharmacy, visit **anthem.com/ pharmacyinformation/rxnetworks.html** and choose the **Base Network** list.

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

Make the most of your pharmacy benefits

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

Drug type		Cost
Tier 1	Preferred generic drugs	**$**
Tier 2	Preferred brand-name and newer, higher-cost generic drugs	**$$**
Tier 3	Nonpreferred brand-name and generic drugs	**$$$**
Tier 4	Preferred specialty drugs (brand name and generic)	**$$$$**

Understanding healthcare terms

Deductible:

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

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

Copay:

A flat fee you pay for covered services, such as doctor visits.

Coinsurance:

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

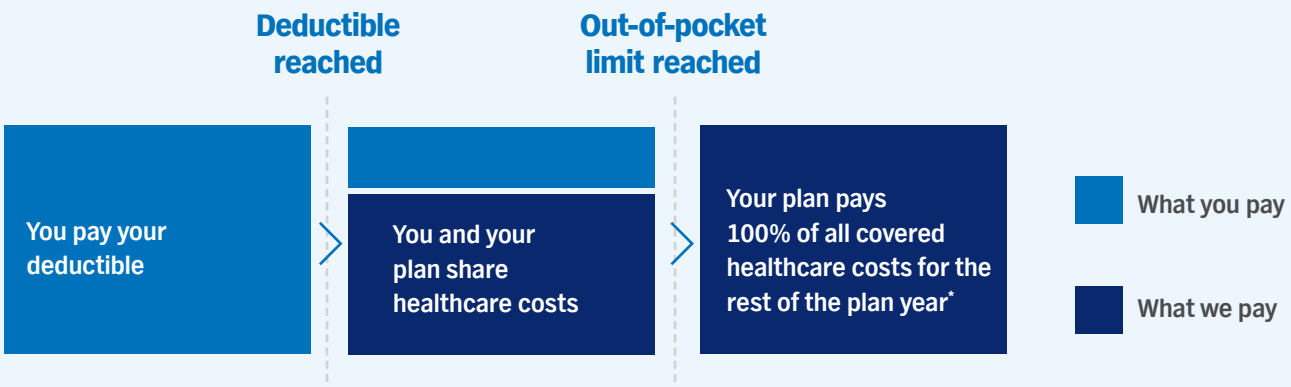
Out-of-pocket limit:

This is the maximum amount you could pay before your plan starts to pay 100% of all covered healthcare costs.* It's the sum of the deductible and coinsurance amounts.

Premium:

The premium, also called a monthly payment, is what you pay for the plan. It's the money that comes out of your paycheck.

What you pay and what your plan pays



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

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

Summary of Benefits of Coverage

(SBC's)

Effective January 1-December 31, 2023

Virginia Private Colleges: Plan 4 PPO

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$750/person or $1,500/family for In-Network Providers. $750/person or $1,500/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care for In-Network Providers. Vision for In-Network and Non-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $150/person or $300/family for Prescription Drugs In-Network Providers. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,250/person or $6,500/family for In-Network Providers. $4,500/person or $9,000/family for Non-Network Providers. This plan has a separate Out of Pocket Maximum of $3,350/person or $6,700/family for Prescription Drugs In-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network	Yes, KeyCare. See www.anthem.com or call (833)	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive

provider?	597-2358 for a list of network providers.	a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	$40/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20 PCP/$40 Spec/visit Or 20% coinsurance in a facility setting	30% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$10/prescription, Prescription Drug deductible does not apply (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	For more information, refer to "National Direct Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	Greater of $40 or 30% coinsurance up to $80/prescription, Prescription Drug deductible applies (retail) and Greater of $80 or 30% coinsurance up to $160/prescription, Prescription Drug deductible applies (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	Greater of $60 or 40% coinsurance up to	Not covered (retail) and Not covered (home delivery)	

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

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)	
		$120/prescription, Prescription Drug deductible applies (retail) and Greater of $120 or 40% coinsurance up to $240/prescription, Prescription Drug deductible applies (home delivery)		
	Tier 4 - Typically Preferred Specialty (brand and generic)	50% coinsurance up to $200/prescription, Prescription Drug deductible applies (retail) and Not covered (home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	20% coinsurance	30% coinsurance	--------none--------
	Emergency medical transportation	20% coinsurance	30% coinsurance	--------none--------
	Urgent care	$20 PCP/$40 Spec./visit	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $20/visit Other Outpatient No charge	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	20% coinsurance	30% coinsurance	Preauthorization
If you are pregnant	Office visits	$20 PCP/$40 Spec. pregnancy for the first 1 visit deductible does not apply.	30% coinsurance	One copayment per pregnancy for office visit services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or	Home health care	No charge	30% coinsurance	90 visits/benefit period.

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

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)	
have other special health needs	Rehabilitation services	ST $20 PCP/$40 Spec/visit PT and OT $30/visit	30% coinsurance	Costs may vary by site of service. *See Therapy Services section.
	Habilitation services	ST $20PCP/$40 Spec/visit PT and OT $30/visit	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	100 days/stay for skilled nursing services. Preauthorization.
	Durable medical equipment	20% coinsurance	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No charge	30% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	$15/visit deductible does not apply	Reimbursed Up to $30	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

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

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

- Bariatric surgery
- Private-duty nursing 16 hours/member/benefit period Facility Setting only
- Chiropractic care 30 visits/benefit period
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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

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

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

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

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

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

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

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

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

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

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

About these Coverage Examples:

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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$750	■ The plan's overall deductible	$750	■ The plan's overall deductible	$750
■ Specialist *copayment*	$40	■ Specialist *copayment*	$40	■ Specialist *copayment*	$40
■ Hospital (facility) *coinsurance*	20%	■ Hospital (facility) *coinsurance*	20%	■ Hospital (facility) *coinsurance*	20%
■ Other *copayment*	$40	■ Other *copayment*	$40	■ Other *copayment*	$40
This EXAMPLE event includes services like: Specialist office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (*ultrasounds and blood work*) Specialist visit (*anesthesia*)		**This EXAMPLE event includes services like:** Primary care physician office visits (*including disease education*) Diagnostic tests (*blood work*) Prescription drugs Durable medical equipment (*glucose meter*)		**This EXAMPLE event includes services like:** Emergency room care (*including medical supplies*) Diagnostic test (*x-ray*) Durable medical equipment (*crutches*) Rehabilitation services (*physical therapy*)	
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$750	Deductibles*	$900	Deductibles	$750
Copayments	$400	Copayments	$200	Copayments	$300
Coinsurance	$2,100	Coinsurance	$1,100	Coinsurance	$200
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$3,310**	**The total Joe would pay is**	**$2,220**	**The total Mia would pay is**	**$1,250**

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

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 597-2358

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 597-2358 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 597-2358 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 597-2358:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (833) 597-2358.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 597-2358 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခွင့်အလမ်းများနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (833) 597-2358 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 597-2358。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (833) 597-2358.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 597-2358.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس بگیرید. (833) 597-2358

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 597-2358.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 597-2358.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 597-2358.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 597-2358.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 597-2358.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें(833) 597-2358 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 597-2358.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 597-2358.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 597-2358.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 597-2358.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 597-2358

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (833) 597-2358 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ(833) 597-2358 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 597-2358.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 597-2358 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833) 597-2358.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih (833) 597-2358.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 597-2358

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 597-2358 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 597-2358 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 597-2358.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 597-2358.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (833) 597-2358 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 597-2358.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 597-2358.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ʻaia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (833) 597-2358.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 597-2358.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 597-2358.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 597-2358.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 597-2358 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (833) 597-2358.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 597-2358 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 597-2358.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833) 597-2358 .

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833) 597-2358.

Language Access Services:

It's important we treat you fairly

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

Virginia Private Colleges: Plan 7 PPO HSA (Embedded Deductible)

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000/person or $6,000/family for In-Network Providers. $3,000/person or $6,000/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care for In-Network Providers. Vision for In-Network and Non-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000/person or $6,000/family for In-Network Providers. $6,000/person or $12,000/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (833) 597-2358 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	0% coinsurance	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% coinsurance	40% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	0% coinsurance (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	For more information, refer to "National Direct Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	0% coinsurance (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	0% coinsurance (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	0% coinsurance (retail) and Not covered (home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	--------none-------
	Physician/surgeon fees	0% coinsurance	40% coinsurance	--------none-------
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network	--------none-------
	Emergency medical transportation	0% coinsurance	Covered as In-Network	--------none-------
	Urgent care	0% coinsurance	40% coinsurance	--------none-------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	Precertification required.
	Physician/surgeon fees	0% coinsurance	40% coinsurance	--------none-------

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

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	0% coinsurance	40% coinsurance	Precertification required.
If you are pregnant	Office visits	0% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	90 visits/benefit period for Home Health and Private Duty Nursing combined.
	Rehabilitation services	0% coinsurance	40% coinsurance	Costs may vary by site of service. *See Therapy Services section.
	Habilitation services	0% coinsurance	40% coinsurance	
	Skilled nursing care	0% coinsurance	40% coinsurance	Preauthorization.
	Durable medical equipment	0% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	0% coinsurance	40% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	$15/visit deductible does not apply	Reimbursed Up to $30	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

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

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

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

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

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

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

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

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

About these Coverage Examples:

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

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

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

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

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

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

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

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

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 597-2358

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 597-2358 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 597-2358 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 597-2358:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (833) 597-2358.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 597-2358 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခွင့်အလမ်းများနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (833) 597-2358 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 597-2358。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (833) 597-2358.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 597-2358.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس بگیرید. (833) 597-2358

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 597-2358.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 597-2358.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 597-2358.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 597-2358.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 597-2358.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें(833) 597-2358 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 597-2358.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 597-2358.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 597-2358.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 597-2358.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 597-2358

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (833) 597-2358 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ(833) 597-2358 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 597-2358.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 597-2358 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833) 597-2358.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih (833) 597-2358.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 597-2358

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 597-2358 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 597-2358 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 597-2358.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 597-2358.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (833) 597-2358 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 597-2358.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 597-2358.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ʻaia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (833) 597-2358.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 597-2358.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 597-2358.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 597-2358.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 597-2358 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (833) 597-2358.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 597-2358 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 597-2358.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833) 597-2358 .

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833) 597-2358.

Language Access Services:

It's important we treat you fairly

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

Virginia Private Colleges: Plan 9 HMO-POS Open Access

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0/person or $0/family for In-Network Providers. $1,000/person or $2,000/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Vision for Non-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $150/person or $300/family for Prescription Drugs In-Network Providers. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$2,500/person or $5,000/family for In-Network Providers. $3,500/person or $7,000/family for Non-Network Providers. This plan has a separate Out of Pocket Maximum of $4,100/person or $8,200/family for Prescription Drugs In-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network	Yes, HealthKeepers. See www.anthem.com or call (833)	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive

provider?	597-2358 for a list of network providers.	a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$25/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	$50/visit	30% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$25 PCP/$50 Spec or Facility copay/visit	30% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	$300/visit	30% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$10/prescription, Prescription Drug deductible applies (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	For more information, refer to "National Direct Drug List" at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section Medications on the VPCBC Preventive Rx List are free of charge and are not subject to the deductible.
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	Greater of $40 or 30% coinsurance up to $80/prescription, Prescription Drug deductible applies (retail) and Greater of $80 or 30% coinsurance up to $160/prescription, Prescription Drug deductible applies (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	Greater of $60 or 40% coinsurance up to $120/prescription, Prescription Drug deductible	Not covered (retail) and Not covered (home delivery)	

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

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)	
		applies (retail) and Greater of $120 or 40% coinsurance up to $240/prescription, Prescription Drug deductible applies (home delivery)		
	Tier 4 - Typically Preferred Specialty (brand and generic)	50% coinsurance up to $200/prescription, Prescription Drug deductible applies (retail) and Not covered (home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300/visit	30% coinsurance	Costs may vary by site of service.
	Physician/surgeon fees	No charge after facility fee is paid	30% coinsurance	Costs may vary by site of service.
If you need immediate medical attention	Emergency room care	$250/visit	Covered as In-Network	--------none--------
	Emergency medical transportation	$100/trip	Covered as In-Network	--------none--------
	Urgent care	$25 PCP/$50 Spec./visit	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$350/day to a maximum of $1,750/admission	30% coinsurance	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	No charge after facility fee is paid.	30% coinsurance	Precertification required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $25/visit Other Outpatient Facility Partial Day: No cost share	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	$350/day to a maximum of $1,750/admission	30% coinsurance	Precertification required.
If you are pregnant	Office visits	$25 PCP/$50 Spec/pregnancy deductible does not apply	30% coinsurance	One copayment per pregnancy for both office visit and childbirth/delivery professional services. Maternity care may
	Childbirth/delivery professional services	$300/pregnancy	30% coinsurance	

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

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)	
	Childbirth/delivery facility services	$350/day to a maximum of $1,750/admission	30% coinsurance	include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	90 visits/benefit period for Home Health and Private Duty Nursing combined.
	Rehabilitation services	$25/visit	30% coinsurance	There is a 30-visit limit for physical and occupational therapy, combined. 30-visit limit for speech therapy. Early Intervention Services Pre-determination of eligibility required.
	Habilitation services	$25/visit	30% coinsurance	
	Skilled nursing care	No charge	30% coinsurance	100 days/benefit period for Inpatient rehabilitation and skilled nursing services combined. Preauthorization.
	Durable medical equipment	No charge	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No charge	30% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	$15/visit	Reimbursed Up to $30	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

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

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

- Bariatric surgery
- Chiropractic care 30 visits/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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

- Private-duty nursing 90 visits/benefit period combined with Home Health
- Routine eye care (Adult) 1 exam/benefit period

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

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

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

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

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

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

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

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

About these Coverage Examples:

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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)		**Managing Joe's Type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$0	■ The plan's overall deductible	$0	■ The plan's overall deductible	$0
■ Specialist *copayment*	$50	■ Specialist *copayment*	$50	■ Specialist *copayment*	$50
■ Hospital (facility) *copayment*	$350	■ Hospital (facility) *copayment*	$350	■ Hospital (facility) *copayment*	$350
■ Other *copayment*	$50	■ Other *copayment*	$50	■ Other *copayment*	$50
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits (*prenatal care*)		Primary care physician office visits (*including disease education*)		Emergency room care (*including medical supplies*)	
Childbirth/Delivery Professional Services		Diagnostic tests (*blood work*)		Diagnostic test (*x-ray*)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (*crutches*)	
Diagnostic tests (*ultrasounds and blood work*)		Durable medical equipment (*glucose meter*)		Rehabilitation services (*physical therapy*)	
Specialist visit (*anesthesia*)					
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles*	$10	Deductibles*	$150	Deductibles*	$10
Copayments	$1,000	Copayments	$600	Copayments	$800
Coinsurance	$0	Coinsurance	$1,100	Coinsurance	$0
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$1,070**	**The total Joe would pay is**	**$1,870**	**The total Mia would pay is**	**$810**

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

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 597-2358

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (833) 597-2358 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 597-2358 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 597-2358:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (833) 597-2358.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 597-2358 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (833) 597-2358 သို့ ခေါ်ဆိုပါ။

Chinese (中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 597-2358。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (833) 597-2358.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 597-2358.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس بگیرید. (833) 597-2358

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 597-2358.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 597-2358.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 597-2358.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 597-2358.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 597-2358.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें(833) 597-2358 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 597-2358.

Igbo (Igbo): Ọ bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (833) 597-2358.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 597-2358.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 597-2358.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 597-2358

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (833) 597-2358 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ(833) 597-2358 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 597-2358.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 597-2358 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (833) 597-2358.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih (833) 597-2358.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 597-2358

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 597-2358 bilbilla.

Pennsylvania Dutch (Deitsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 597-2358 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (833) 597-2358.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 597-2358.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ (833) 597-2358 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 597-2358.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 597-2358.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ʻaia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (833) 597-2358.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 597-2358.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 597-2358.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 597-2358.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 597-2358 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (833) 597-2358.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 597-2358 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 597-2358.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (833) 597-2358 .

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833) 597-2358.

Language Access Services:

It's important we treat you fairly

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

Anthem Medical

Summary of Benefits

Effective January 1-December 31, 2023

This guide provides Anthem's general exclusions and limitations which may vary from the Plan Document. Please consult the Virginia Private Colleges Benefits Consortium, Inc. Health Plan Document for a list of exclusions and limitations.

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Plan 4 PPO

Your Network: KeyCare

This schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductible and Coinsurance. In Network Discounts and Allowable Charges, as set forth in the Plan Documents to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Documents.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. . Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$750 person / $1,500 family	$750 person / $1,500 family
Out-of-Pocket Limit	$3,250 person / $6,500 family	$4,500 person / $9,000 family
When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Mental Health and Substance Abuse care	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit medical deductible does not apply	
Specialist Care	$40 copay per visit medical deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Specialist Care	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *All office visit copayments count towards the same 1 visit limit. Copay only applies to initial visit.*	$20 PCP/ $40 Spec.copay per pregnancy for the first 1 visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$40 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	$20 PCP/$40 Spec. copay per visit medical deductible does not apply‡	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	$20 PCP/$40 Spec. copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Preferred Reference Lab	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray		
Office	$20 PCP/$40 Spec. copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$20 PCP/ $40 Spec. copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit medical deductible does not apply	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Visit		
Facility Fees	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor Services	0% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Freestanding Surgical Center	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period.*	No charge	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services *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.*		
Office	PT/OT $30 copay /visit ST $20 PCP/ $40 Spec copay/ visit medical deductible does not apply	30% coinsurance after medical deductible is met
Outpatient Hospital	PT/OT $30 copay/visit ST $20 PCP/$40 Spec. copay/visit medical deductible does not apply	30% coinsurance after medical deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Hospice	No charge	30% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after medical deductible is met	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech therapy.	Office Visit: $20 for each visit to a family or general practitioner, internist or pediatrician; $40 for each visit to a specialist(deductible does not apply) Outpatient Facility: $40 for each visit to a specialist(deductible does not apply)	30% coinsurance after medical deductible is met
Applied Behavioral Analysis	No charge (deductible does not apply)	30% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$150 person / $300 family	Not covered
Pharmacy Out-of-Pocket Limit	$3,350 person/ $6,700 family	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the National Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Preventive Drugs *Your Pharmacy cost share is waived for drugs included on the VPCBC Preventive RX drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and is not subject to the deductible.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, Pharmacy deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	Greater of $40 or 30% coinsurance up to $80 per prescription after Pharmacy deductible is met (retail) and Greater of $80 or 30% coinsurance up to $160 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	Greater of $60 or 40% coinsurance up to $120 per prescription after Pharmacy deductible is met (retail) and Greater of $120 or 40% coinsurance up to $240 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	50% coinsurance up to $200 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.
- 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 and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge.
- 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 provider's 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.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.

- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Any amount you pay toward your medical deductible during the 4th quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.

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.

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 597-2358.

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.

Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Plan: Plan 7 PPO HSA (Embedded Deductible)

Your Network: KeyCare

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 person / $6,000 family	$3,000 person / $6,000 family
Out-of-Pocket Limit	$3,000 person / $6,000 family	$6,000 person / $12,000 family
The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits - Online visits with Doctors who also provide services in person**		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	0% coinsurance after deductible is met	
Specialist Care	0% coinsurance after deductible is met	
Visits in an Office		
Primary Care (PCP)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	0% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred Reference Lab	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility Visit		
Facility Fees	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services *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.*		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	40% coinsurance after deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech Therapy	0% of the amount the health care professionals in our network have agreed to accept for their services	40% coinsurance after medical deductible is met
Applied Behavioral Analysis	0% of the amount The health care professionals in our network have agreed to accept for their services	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the National Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Preventive Drugs *Your Pharmacy cost share is waived for drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. The list is free of charge and is not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	0% coinsurance after deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay deductible does not apply	Reimbursed Up to $30

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Language Access Services:

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Your summary of benefits

Anthem HealthKeepers

Anthem® HealthKeepers Inc.

Your Plan: Virginia Private Colleges: Plan 9 HMO-POS Open Access

Your Network: HealthKeepers

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network dicounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please reat this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at http://www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

.Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$0 person / $0 family	$1,000 person / $2,000 family
Out-of-Pocket Limit	$2,500 person / $5,000 family	$3,500 person / $7,000 family
When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible. Your copays, coinsurance and deductible count toward your out of pocket amount(s). In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after medical deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	$25 copay per visit	30% coinsurance after medical deductible is met

.Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Mental Health and Substance Abuse care	$25 copay per visit	30% coinsurance after medical deductible is met
Specialist	$50 copay per visit	30% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	$5 copay per visit	
Specialist Care	$50 copay per visit	
Visits in an Office		
Primary Care (PCP)	$25 copay per visit	30% coinsurance after medical deductible is met
Specialist Care	$50 copay per visit	30% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *Copay only applies to initial visit.*	$25 PCP/$50 Spec. copay per pregnancy for the first 1 visit $300 per pregnancy	30% coinsurance after medical deductible is met
Retail Health Clinic	$25 copay per visit	30% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$25 copay per visit	30% coinsurance after medical deductible is met

.Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Services in an Office		
Allergy Testing	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Chemo/Radiation Therapy	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	$50 copay per visit	30% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	No charge	30% coinsurance after medical deductible is met
Surgery	$25 PCP/$50 Spec. copay per visit‡	30% coinsurance after medical deductible is met
Diagnostic Services		
Lab		
Office	$25 PCP/$50 Spec. copay per visit	30% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	30% coinsurance after medical deductible is met
Outpatient Hospital	No charge	30% coinsurance after medical deductible is met
X-Ray		
Office	$25 PCP/$50 Spec. copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$50 copay per visit	30% coinsurance after medical deductible is met

.Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$300 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$25 PCP/$50 Spec. copay per visit	30% coinsurance after medical deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	$100 copay per trip	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit	30% coinsurance after medical deductible is met
Facility Visit		
Facility Fees	$25 copay per visit	30% coinsurance after medical deductible is met
Doctor Services	No charge	30% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$300 copay per visit	30% coinsurance after medical deductible is met
Freestanding Surgical Center	$300 copay per visit	30% coinsurance after medical deductible is met

.Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services		
Hospital	No charge	30% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	$350 copay per day to a maximum of $1,750 per admission	30% coinsurance after medical deductible is met
Doctor and other services	No charge	30% coinsurance after medical deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limits are combined for all home health services.*	No charge	30% coinsurance after medical deductible is met
Rehabilitation services *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. Limit is combined In-Network and Non-Network.*		
Office	$25 copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$25 copay per visit	30% coinsurance after medical deductible is met
Cardiac rehabilitation Limit is combined In-Network and Non-Network across all outpatient settings.		
Office	$25 PCP/ $50 Spec. copay per visit	30% coinsurance after medical deductible is met
Outpatient Hospital	$50 copay per visit	30% coinsurance after medical deductible is met

.Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission. Limit is combined In-Network and Non-Network.*	No charge	30% coinsurance after medical deductible is met
Hospice	No charge	30% coinsurance after medical deductible is met
Durable Medical Equipment	No charge	30% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network.*	No charge	30% coinsurance after medical deductible is met
Autism Spectrum Disorder (ASD) Therapeutic Care: unlimited physical, occupational and speech Therapy. Applied Behavioral Analysis	**Office Visit: $25** for each visit **Outpatient Facility: $25** for each visit **20%** of the amount the health care professionals in our network have agreed to accept for their services	**30%** coinsurance after medical deductible is met **30%** coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$150 person / $300 family	Not covered
Pharmacy Out-of-Pocket Limit	$4,100 person / $8,200 family	Not covered
Prescription Drug Coverage *Cost shares for drugs included on the National Direct drug list appear below. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Drug cost share assistance programs may be available for certain specialty drugs.*		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Home Delivery Pharmacy *Maintenance medication are available through CarelonRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Preventive Drugs *Your Pharmacy cost share is waived for drugs included on the VPCBC Preventive Rx drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis. This list is free of charge and are not subject to the deductible.*		
Tier 1 Preventive - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 2 Preventive - Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	No charge	Not covered (retail and home delivery)
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription after Pharmacy deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	Greater of $40 or 30% coinsurance up to $80 per prescription after Pharmacy deductible is met (retail) and Greater of $80 or 30% coinsurance up to $160 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	Greater of $60 or 40% coinsurance up to $120 per prescription after Pharmacy deductible is met (retail) and Greater of $120 or 40% coinsurance up to $240 per prescription after Pharmacy deductible is met (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	50% coinsurance up to $200 per prescription after Pharmacy	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible is met (retail) and Not covered (home delivery)	

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Children's Vision (up to age 19) **Child Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30
Adult Vision (age 19 and older) **Adult Vision Deductible**	$0 person	$0 person
Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- 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 an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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 provider's charge.
- 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 provider's 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.

- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Out of pocket prescription drug cost do not count towards the Medical out of pocket maximum.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Any amount you pay toward your medical deductible during the 4th quarter of each calendar year (Oct-Dec) will apply not only to your deductible for that year but will also apply to your deductible for the following year.

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

This benefit summary is not to be distributed without also providing access on limitations and exclusions that apply to our medical plans.

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Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 597-2358

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

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 597-2358 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 597-2358:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 597-2358。

Farsi (فارسي) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 597-2358 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 597-2358.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 597-2358.

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Blue View Vision℠

Exam Only A15 Plan

Anthem
And Its Affiliate HealthKeepers, Inc.

Welcome to your Blue View Vision plan!

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

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

USING YOUR BLUE VIEW VISION PLAN

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

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

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

OUT-OF-NETWORK

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

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

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

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

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

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

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

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

GLASSES.COM · contactsdirect · LensCrafters · Pearle Vision · Target Optical · Sears Optical · JCPenney | optical

ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM

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

Stay on top of your health

Use your preventive care benefits

Anthem

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

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

Preventive care vs. diagnostic care

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

Adult preventive care

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

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)[2]
- Depression screening
- Diabetes screening (type 2)[3]
- Eye chart test for vision[4]
- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hepatitis C virus (HCV) screening
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for those ages 55 to 80 who have a history of smoking 30 packs or more per year and still smoke, or who have quit within the past 15 years[2]
- Obesity: related screening and counseling[3]
- Prostate cancer screenings, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

Women's preventive care:

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met[5]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling[6,7,8]
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening[7]
- Interpersonal and domestic violence: screening and counseling
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV, and depression[7]
- Well-woman visits

Immunizations:

- Coronavirus disease (COVID-19)
- 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)

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

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Child preventive care

Preventive physical exams, screenings, and tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure screening
- Cervical dysplasia screening
- Cholesterol and lipid (fat) levels screening
- Depression screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer counseling for those ages 6 months to 24 years with fair skin
- Tobacco use: related screening and behavioral counseling
- Vision screening, when done as part of a preventive care visit[4]

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

Coverage for pharmacy items

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

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

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

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease (CVD), preeclampsia, and colorectal cancer in adults younger than age 70
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name 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 tooth decay in children ages 5 and younger
- Fluoride supplements for children ages 6 and younger

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

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria[2]
- Contraceptives, including generic prescription drugs and OTC items like female condoms and spermicides[7]
- Folic acid for women ages 55 or younger who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

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

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 You may be required to receive preapproval for these services.
3 The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.
4 Some plans cover additional vision services. Please see your contract or *Certificate of Coverage* for details.
5 Check your medical policy for details.
6 Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.
7 This benefit also applies to those younger than age 19.
8 Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay, or coinsurance). Contact the provider to see if such services are available.

See a doctor anytime, anywhere — no appointment needed

The ER isn't your only option when you need urgent care

If you think you're experiencing a life-threatening emergency or your health is in serious jeopardy, you should always call 911 or go to the emergency room (ER) immediately. However, if you need nonemergency care quickly, but your primary care doctor isn't available, it's important to know you have options besides the ER.

Now more than ever, people are turning to virtual care (also known as telehealth or telemedicine) from experienced doctors on their phones, tablets, and computers. It's a convenient, affordable choice when you want help right away with urgent issues.

Why virtual care?

Help is available 24/7	Affordable care option	Reliable care you can trust
Fast doctor visits through your phone, tablet, or computer — no appointments or waiting rooms	Virtual visits cost significantly less than a trip to the emergency room[1]	Manage your urgent care needs and receive expert advice, treatment plans, and prescriptions[2]

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What can virtual doctors treat?

Virtual doctors can typically treat conditions and symptoms including:[3]

- Colds
- Sore throats
- Headaches
- Mild fevers
- Stomach aches
- Uncomplicated urinary tract infections (UTIs)
- Care management for certain chronic conditions
- Sprained wrists, fingers, or ankles
- Back pain
- Joint pain

As part of your treatment plan, your virtual doctor can also:

- Prescribe certain medications.
- Recommend specialists.
- Order lab tests.
- Tell you if it's time to seek care in person.
- Recommend over the counter medications or treatments.

Are you ready to try a virtual visit?

Next time you're not feeling well, telehealth may be able to help.

Download the Sydney Health℠ app today

Use the Sydney Health℠ app for a virtual visit with a doctor 24/7. Video call, text, or chat with a doctor who can help you feel better — no appointment required.

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

You can also ask your primary care doctor if they offer telehealth visits.

1 Costs are calculated according to the member's estimated out-of-pocket costs and average health plan copays. Care outside of your network may cost more out of pocket. Call the Member Services number on your ID card if you have questions about your plan.

2 Your doctor will prescribe you medications as they see fit.

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

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Anthem LiveHealth ONLINE

Connect with virtual support using Sydney Health and **anthem.com**

Now you can connect to the care you need through the Sydney Health mobile app or **anthem.com**. Have a live video visit with licensed therapists, board-certified psychologists, and psychiatrists through private video visits on your computer with a camera.

Faster support when you need it

If you're feeling anxious or depressed, you can talk with a therapist online. Appointments are available seven days a week. In most cases, you can set up a visit and see a therapist in seven days or less.[2]

You can also visit with a psychiatrist by appointment for support on managing your medication.[3] Unlike therapists, who offer counseling support, psychiatrists can provide an evaluation and medication management to help if you have a common behavioral health condition.

With your Anthem health plan, the cost of an online visit is the same as the cost for an in-person visit.

Commonly treated conditions:

- Anxiety
- Stress
- Depression
- Grief
- Bipolar disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder

Make time for your mental health

Use the Sydney Health mobile app or visit **anthem.com**.
Download Sydney Health on the App Store® or Google Play™.

Download on the App Store | ANDROID APP ON Google play

1 Appointments subject to availability
2 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using Sydney Health. Psychiatrists on Sydney Health will not offer counseling or talk therapy.
3 LiveHealth Online internal data.

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 800-273-8255 (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. Sydney Health does not offer emergency services.

Sydney and Sydney Health are service marks of CareMarket, Inc.

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Expanding your virtual care options

Find complete care support, on your time, through the **Sydney Health app**

Visit with a doctor at your convenience

Accessing the care you need, when you need it, matters. That's why our Sydney℠ Health mobile app connects you to a team of doctors ready to help you on your time. There are two secure ways to find no- or low-cost care through our app:

1 Chat with a doctor 24/7 without an appointment

- Urgent care support for health issues, such as allergies, a cold, or the flu.
- New prescriptions for concerns such as a cough or a sinus infection.

2 Schedule a virtual primary care appointment

- Routine care, including wellness check-ins and prescription refills.
- Personalized care plans for chronic conditions, such as asthma or diabetes.

Assess your symptoms with the Symptom Checker

When you're sick, you can use the Symptom Checker on Sydney Health to answer a few questions about how you're feeling. That information is run against millions of medical data points to provide care advice tailored to you.

Save money and time with virtual care

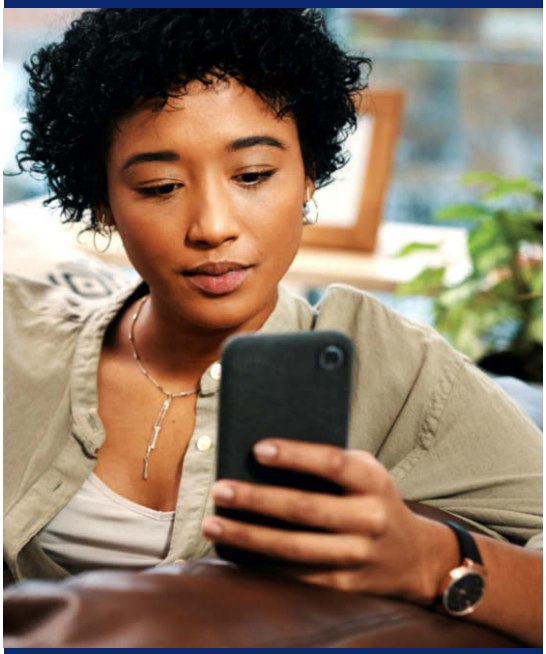
Sydney Health brings care to you anywhere, anytime. The Symptom Checker is always free to use, while virtual primary care visits and on-demand urgent care through the app are available at no or low cost.

Download our Sydney Health mobile app today.

Set up your account right away and it will be ready to use when you need it.

GET IT ON Google Play

Download on the App Store



85% of virtual visits **resolve** the person's need.*

* K Health analysis of Q4 2020 visit dispositions.

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Welcome to your pharmacy plan

Here's a quick guide to your January 2023 benefits and how to get the most out of them

Anthem®
And Its Affiliate HealthKeepers, Inc.

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Here are your pharmacy benefits in a nutshell

We know you're busy, so we created a quick and easy guide to your benefits. It includes tips on how to make the most of your coverage and save money while you're at it.

First things first. Have you registered at anthem.com yet?

It's the fastest and easiest way to get all of your personalized pharmacy benefits information. At anthem.com, you can do things like:

- Find a pharmacy.
- Check your drug list.
- Compare drug costs.
- Switch to home delivery or refill a prescription.
- Check your claims status and history.
- Check your copay, deductible or coinsurance amounts.

There's an app for all of that, too. Sydney makes it easy to manage your pharmacy benefits from wherever you are. You can find it at the Apple Store® (iOS) or on Google Play (Android).

Here's what your plan covers

- Brand-name and generic drugs on your drug list
- Some preventive drugs at little or no cost to you
- Most specialty drugs if you have an ongoing health issue or serious illness

Your drug list

Your plan uses the National Direct Tier 4. It includes hundreds of generic and brand-name prescription drugs.

You can get a sneak peek of your drug list at www.anthem.com/nationaldirect4tierva to see if a drug you take is covered. For more details, log in at anthem.com. If your drug isn't on the list, you'll see other options. Keep in mind, changes can be made to your drug list. So you may want to check it when you get a new prescription.

Drugs are grouped in tiers. Your share of the cost will depend on which tier your drug is on. The lower the tier, the lower your cost.

Your plan uses the Preferred Generics program. This means when there's a generic option available and you choose to go with the brand-name drug instead, you'll pay more. Check with your doctor to see if there's a generic option that's right for you — it'll save you money!

Your cost

Your share of drug costs — including any copay or coinsurance amounts — depends on your plan and which pharmacy you use. You'll find this information when you log in at anthem.com. Or ask your employer for a copy of your Summary of Benefits.

Need to fill a prescription? Here we go.

You have plenty of choices about how and where to get your prescription medicine, including local pharmacies in your plan or convenient home delivery.

Retail pharmacies

Your plan includes nearly 70,000 pharmacies nationwide. You'll save the most money when you use one of these pharmacies. It's easy to find one near you. Just log in at anthem.com, find **Locate a Pharmacy** and type in your ZIP code.

Home delivery

If you take medicines regularly or need them on a long-term basis, you can save time with home delivery. You may also save money. You can get up to a 90-day supply delivered to your door, with free standard shipping. Sign up at anthem.com.

If you need any prescriptions refilled, you'll have to get a new 90-day prescription from your doctor. You can call 1-866-281-4279 to get started.

Specialty pharmacy

If you have a complex health condition that requires specialty drugs for your treatment — drugs that may need special handling or that you may get by injection or infusion — you'll need to get them through IngenioRx Specialty Pharmacy.*

To view a list of specialty drugs that will require you to go to a network specialty pharmacy to fill your prescription when covered by your plan, visit anthem.com/pharmacyinformation and select the **Exclusive Specialty Drug List**.

*IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross and Blue Shield.

Want to save on drug costs? Here's how!

- Take medicines on your plan's **drug list**.
- Choose drugs on **Tier 1** for your lowest cost share.
- Find out if there are **generic or over-the-counter options** that may work for you.
- See how much your cost could be with our ***Price a Medication*** tool at anthem.com.
- Use a pharmacy **in your plan**.
- Get **90-day supplies** of the medicines you take regularly.

Remember to always talk to your doctor before making any change in your medicine.

Here are a few more things to know about your drug coverage

(Don't worry, we'll keep it short.)

Some medications require taking certain steps before they're covered by your plan. Here are a few you need to know about:

- **Prior authorization (PA).** You may need to get our approval before a pharmacy can fill your prescription. The expiration date on your PA won't change, but it'll transfer with your new prescription drug plan.
- **Step therapy (ST).** You may need to try one or more other drugs before we'll cover the one your doctor wants you to take.
- **Quantity limits (QL).** Your plan may limit how much of a medicine you can get each month to help protect your health.
- **Dose optimization (DO).** You may be able to switch from taking a drug twice a day to taking it once a day at a higher strength.

Need help with any of this?

It's important for you to understand your pharmacy benefits and how they work. That's why we put this quick guide together for you. If you still have questions, we're here to answer them. Just give us a call at the Member Services number on your ID card or visit anthem.com/faqs/virginia/pharmacy.

It's your call

You choose how you want to reach us — we'll make sure you get answers

All you want is for someone to answer your questions, right? To make it easy to understand your plan. Or help you figure out the next steps in dealing with a health issue. We hear you. And we're here for you, too.

Anthem Health Guide: supporting you with answers and guidance

You can reach us by phone, mobile app, email or even chat with us online via your computer or mobile device. Whatever you choose, you'll get a health guide who's ready to answer your questions and help you make the most of your health plan benefits.

It takes a team

Our health guides work closely with health care professionals, like nurses, health coaches and social workers, to provide personalized and consultative support.

They can help you:

- Connect with the right benefits and programs for your health care needs, including:
  - Musculoskeletal support to help manage bone, joint and muscle pain
  - Pregnancy support to keep you healthy while you're expecting
  - Nurse care manager support for managing chronic conditions such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), coronary artery disease and heart failure
  - Cancer support for you, family members and caregivers before, during and after treatment
  - Behavioral health support if you or a family member are experiencing stress, depression and anxiety, or are dealing with drug and alcohol abuse or other personal issues
- Stay on top of your follow-up and preventive care with reminders and appointment-scheduling support.
- Compare costs for health care services, find in-network doctors and much more.

It starts with making sure you can reach us any way you want

- **Call the number on your ID Card**
- **Chat with us online, email us or set up a return call by:**
  1. **Logging in at anthem.com**
  2. **Choosing Customer Support**
  3. **Selecting Contact Us**
  4. **Picking your preferred communication option**
- **Use our free Anthem Blue Cross and Blue Shield mobile app**

Anthem®

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Meet your new health champion

Enhanced Personal Health Care doctors go above and beyond for you

Whether you go to the doctor rarely or often, you should find a primary care physician (PCP) you like and trust. Checking out Enhanced Personal Health Care (EPHC) doctors is a great way to start your search. Enhanced Personal Health Care professionals (including primary care doctors and other medical staff) have agreed to provide high-quality care and focus on your whole health — not just your symptoms. In fact, Anthem Blue Cross and Blue Shield members who choose an EPHC doctor are happier with their doctors and their overall health.*

Your Enhanced Personal Health Care doctor has agreed to go above and beyond and:

- Focus on preventing illnesses and helping you get healthy faster and stay healthy longer.
- Coordinate your overall health care to avoid any gaps in care. This entails things like setting up appointments with specialists to ensuring you're following your prescription plan and getting the right tests and screenings regularly.
- Help you avoid unnecessary medical services and tests, saving you money and reducing stress.
- Use specialized health information to help them better coordinate and manage your care.
- Be available to you 24/7 through extended office hours, after-hours call coverage and sometimes even online.
- Spend extra time with you to get to know you and your health goals.
- Contact you when you're due for a preventive exam or screening.

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Choose the kind of professional who's right for you

- **Family practice/general practice** — These doctors offer a wide range of care, from check-ups to pregnancy care. This type of doctor might be a good choice if you want to keep all of your family members under the same doctor's care. A doctor who treats everyone in a family can sometimes get a better view of each person's health.
- **Internal medicine** — Internal medicine doctors mainly treat adults and offer a range of care, including preventive care. But they may have special knowledge about certain health problems. So if you have a long-term health problem, an internist who also focuses on that particular problem may be a good fit for you.
- **Pediatricians** care for infants, children, and adolescents.
- **Nurse practitioners and physician assistants** aren't doctors, but they've had lots of training. They can do many of the same things that doctors do.

Ready to find your Enhanced Personal Health Care doctor?

1. Log in or register at **anthem.com**.
2. Under **Find a Doctor**, enter your location and search distance. Be sure to select the boxes *for Able to serve as primary care physician* (PCP) and *Enhanced Personal Health Care*.
3. Choose **Search** and you'll see a list of available doctors near you.

* AEPHC Patient Experience Survey Results. In 2015, 2,751 EPHC patient interviews were conducted across four distinct EPHC patient populations. 746 interviews for non-EPHC Group. Analyses conducted across patient experience domains to identify performance of EPHC providers over time, and, comparative performance to non-EPHC providers.

Choose an easier way to better health

Health and wellness programs designed for your unique needs

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

ConditionCare

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

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

Future Moms

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

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

24/7 NurseLine

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

These nurses can:

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

Get the support you need

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

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

Anthem®
And Its Affiliate HealthKeepers, Inc.

MVASH1316A VPOD Rev. 7/18

A program focused on helping you improve your health

Introducing digital diabetes prevention coaching

Roughly 88 million Americans are living with prediabetes but 84% aren't even aware they have it.[1] Prediabetes often doesn't cause symptoms, but it does increase the risk of developing type 2 diabetes, heart disease, and stroke. That's why Anthem has partnered with Lark to offer a diabetes prevention program that can help you determine if you're at risk for prediabetes and if needed, take steps to address it.

This program can help you:

- Lose weight
- Eat healthier
- Increase activity
- Sleep better
- Manage stress

Better health is within your reach

You can participate in this program at no extra cost as part of your health plan. Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

Anthem lark

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Weight loss with Lark

Losing weight can make a big difference in lowering your risk for type 2 diabetes. Lark members lose an average of 4.2% of their body weight in 12 months on the diabetes prevention program.[2] As part of the program, you receive a wireless scale at no extra cost to help you track your weight loss progress. Your scale also syncs with the Lark app so you can share updates with your coach.

24/7 coaching support

Losing weight and making lifestyle changes can feel intimidating even if you know it can lead to better health. Your coach can help you stay motivated. Send your coach a message anytime from anywhere and receive an immediate response and extra support when you need it most. During the course of the program, your coach will:

- Be available 24/7 through the Lark mobile app to provide personalized coaching.
- Customize your program based on your food preferences and lifestyle.
- Provide educational information on prediabetes and preventing type 2 diabetes.
- Help you learn about how stress affects your health and how to cope with it.

You are in control of your health. Prevent diabetes and start improving your overall health and well-being today.

Learn if you are at risk for prediabetes

Go to **lark.com/anthem** and take a quick one-minute survey to see if you could benefit from Lark's diabetes prevention program.

1 Centers for Disease Control and Prevention website: *Prediabetes - Your Chance to Prevent Type 2 Diabetes* (accessed October 2020): cdc.gov.

2 Lark internal data

Diabetes Prevention Program is provided by Lark, an independent company.

Save money with discounts at anthem.com

As an Anthem member, you qualify for discounts on products and services that help promote better health and well-being.* These discounts are available through SpecialOffers to help you save money while taking care of your health.

Vision, hearing and dental

Glasses.com™ and 1-800-CONTACTS® — Shop for the latest brand-name frames at a fraction of the cost for similar frames at other retailers. You are also entitled to an additional $20 off orders of $100 or more, free shipping and free returns.

EyeMed — Take 30% off a new pair of glasses, 20% off non-prescription sunglasses and 20% off all eyewear accessories.

Premier LASIK — Save $800 on LASIK when you choose any "featured" Premier LASIK Network provider. Save 15% with all other in-network providers.

TruVision — Save up to 40% on LASIK eye surgery at more than 1,000 locations.

Nations Hearing — Receive hearing screenings and in-home service at no additional cost. All hearing aids start at $599 each.

Hearing Care Solutions — Digital instruments start at $500, and a hearing exam is free. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, batteries for two years and unlimited visits for one year.

Amplifon — Take 25% off, plus an extra $50 off one hearing aid; $125 off two.

ProClear™ Aligners — Take $1,200 off a set of custom aligners. You can improve your smile without metal braces and time-consuming dental visits. Your order is 50% off and comes with a free whitening kit.

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Fitness and health

Active&Fit Direct™ — Active&Fit Direct allows you to choose from more than 11,000 participating fitness centers nationwide for $25 a month (plus a $25 enrollment fee and applicable taxes). Offered through American Specialty Health Fitness, Inc.

FitBit — Work toward your fitness goals with Fitbit trackers and smartwatches that go with your lifestyle and budget. Save up to 22% on select Fitbit devices.

Garmin — Take 20% off select Garmin wellness devices.

Jenny Craig® — Join this weight loss program for free. Jenny Craig provides you with everything you need, making it easier to reach your goals. You can save $200 in food, in addition to free coaching, with minimum purchase. Save an extra 5% off your full menu purchase. Details apply.

ChooseHealthy® — Discounts are available on acupuncture, chiropractic, massage, podiatry, physical therapy and nutritional services. You also have discounts on fitness equipment, wearable trackers and health products, such as vitamins and nutrition bars.

GlobalFit — Discounts apply on gym memberships, fitness equipment, coaching and other services.

Family and home

23andMe — Take $40 off each Health + Ancestry kit. Save 20% on a 23andMe kit and learn about your wellness, ancestry and more.

Safe Beginnings® — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

Nationwide Pet Insurance — Receive an automatic 5% discount when you enroll through your company or organization. Save up to 15% when you enroll multiple pets.

ASPCA Pet Insurance — Take 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

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

LifeMart® — Take advantage of great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

Medicine and treatment

SelfHelpWorks — Choose one of the online Living programs and save 15% on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep or face an alcohol problem.

Brevena — Enjoy a 41% discount on BREVENA® skin care creams and balms for smooth, rejuvenated skin from face to foot.

Puritan's Pride® — Choose from a large selection of discounted vitamins, minerals and supplements from Puritan's Pride.

Allergy Control Products and National Allergy Supply — Save up to 25% on select doctor-recommended products such as allergy-friendly bedding, air purifiers and filters, asthma products and more. Orders over $59 ship for free by ground within the contiguous U.S.

To find the discounts available to you, log in to **anthem.com**, choose **Care** and select **Discounts**.

Your SpecialOffers discounts are part of our effort to support your personal health journey. Taking care of your health can be easier with the savings offered through your health plan.

*** All discounts are subject to change without notice.**

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Notice of privacy practices

Important information about your rights and our responsibilities

THIS NOTICE DESCRIBES HOW MEDICAL, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE READ CAREFULLY.

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Protecting your personal health information is important. Each year, we're required to send you specific information about your rights and some of our duties to help keep your information safe. This notice combines three of these required yearly communications:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

Would you like to go paperless and read this online next time? Go to **anthem.com** and sign up to get these notices by email.

State notice of privacy practices

When it comes to handling your health information, we follow state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.
- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give you additional rights to limit sharing your health information. Please call the Member Services phone number on your ID card for more details.

Your personal information

Your nonpublic (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may get your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company — without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt out, we'll let you know. We'll also tell you how you can let us know you don't want your PI used or shared for an activity you can opt out of.

HIPAA notice of privacy practices

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our own rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your protected health information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to take care of your account and benefits, or to pay claims for health care you get through your plan.

Health care operations: We collect, use and share PHI for your health care operations.

Treatment activities: We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may use publicly and/or commercially available data about you so you can get available health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations, visit **anthem.com/privacy** for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests.

You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we email you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

Your protected health information (continued)

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways — usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medicines
  - Reporting suspected abuse neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing workers' compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

Race, ethnicity and language: We may receive race, ethnicity and language information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity and language information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you.
- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI.
- Ask for a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.
- Call Member Services at the phone number on your ID card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call 1-844-203-3796 to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us at the Member Services phone number on your ID Card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting **hhs.gov/ocr/privacy/hipaa/complaints/**. We will not take action against you for filing a complaint.

Contact information

You may call us at the Member Services phone number on your ID card. Our representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision is noted in the footer at the end of this document.

Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

You'll pay your usual deductible, copay and/or coinsurance. For details, contact your plan administrator.

For more information about the Women's Health and Cancer Rights Act, go to the United States Department of Labor website at **www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra**.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently based on race, color, national origin, sex, age or disability. If you have disabilities, we offer free aids and services. If your main language isn't English, we offer help for free through interpreters and other written languages. 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 through one of these ways:

- Write to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160 Richmond, VA 23279.
- 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.
- Call **1-800-368-1019** (TDD: 1-800-537-7697).
- Go online at **ocrportal.hhs.gov/ocr/portal/lobby.jsf** and fill out a complaint form at **hhs.gov/ocr/office/file/index.html**.

Get help in your language

One more right that you have the right to get this information in your language for free. If you'd like extra help to understand this in another language, call the Member Services number on your ID card (TTY/TDD: 711).

Aside from helping you understand your privacy rights in another language, we also offer this notice in a different format for members with visual impairments. If you need a different format, please call the Member Services number on your ID card.

Language Assistance

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمک‌ها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که رب روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo

Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áajį' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áajį' hodíílnih.

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Revision 5/18

102256VAMENBVA VPOD

The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

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

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

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

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

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

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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

Determining the primary and secondary plans

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

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

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered (PPO)

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

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

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

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

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    This Exclusion does not apply to:

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

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

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

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

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

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

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

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

21) **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.

22) **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.

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

24) **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.

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

26) **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.

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

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

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

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

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

30) **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.

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

32) **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.

33) **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.

34) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

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

35) **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.

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

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

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

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

39) **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.

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

41) **Home Care**

    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

    b) Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.

42) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

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

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

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

46) **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.

47) **Medical Equipment, Devices, and Supplies**

   a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

   b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

   c) Non-Medically Necessary enhancements to standard equipment and devices.

   d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

   e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

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

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

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

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

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

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

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

55) **Personal Care, Convenience and Mobile/Wearable Devices**

   a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

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

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

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

   e) Hypo-allergenic pillows, mattresses, or waterbeds,

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

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

56) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.

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

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

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

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

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

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

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

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

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

63) **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).

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

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

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

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

68) **Vision Services**

   a) Eyeglass lenses, frames, or contact lenses, unless listed as covered in this Booklet.

   b) Safety glasses and accompanying frames.

   c) For two pairs of glasses in lieu of bifocals.

   d) Plano lenses (lenses that have no refractive power).

   e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.

   f) Vision services not listed as covered in this Booklet.

   g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.

h) Blended lenses.

i) Oversize lenses.

j) Sunglasses and accompanying frames.

k) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.

l) For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.

m) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.

69) **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.

70) **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.

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

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
9. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
10. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
11. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
12. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

    This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
13. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
14. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the

"Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.

15. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
16. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
17. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
18. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
19. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
20. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
21. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
22. **Non-approved Drugs** Drugs not approved by the FDA.
23. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
24. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, *nutritional formulas and dietary supplements that you can buy over the counter* and those you can get without a written Prescription or from a licensed pharmacist.
25. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

    The exception to this Exclusion is described in "Covered Prescription Drugs" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.
26. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
27. **Over-the-Counter Items** Drugs, devices and products permitted to be dispensed without a prescription and available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.
28. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
29. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
30. **Weight Loss Drugs** Any Drug mainly used for weight loss.

2021 exclusions are provided for illustrative purposes only. 2022 exclusions will be provided upon regulatory approval.

PPO disclaimer - 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 is an independent licensee of the Blue Cross and Blue Shield Association.

We're here for you – in many languages

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

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

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

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

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

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

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

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

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

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

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

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

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

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

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

TTY/TTD:711

It's important we treat you fairly

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

Protecting your privacy

How we keep your information safe and secure

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

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

How we help manage your care

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

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

Special enrollment rights

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

- **If you had another health plan that was canceled**. If you, your dependents, or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in one of our plans.
- **If you have a new dependent**. You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes**. You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible..
  - You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

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For full details, read your plan document, which has all the details about your plan. You can it find on **anthem.com**.

Notes

Notes

Your plan is here for you to use

If you would like extra help

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

Reach a health guide by calling the number on your member ID card. You also can go to **anthem.com** to send a secure email or chat with them online.

Anthem

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