

Administered by Anthem
Blue Cross and Blue Shield

Henrico County General Government and Public Schools

2027 out-of-area PPO plan healthcare benefits enrollment guide

Anthem

County of Henrico
General Government

HENRICO COUNTY PUBLIC SCHOOLS
HCPS

Fast facts

Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. have been serving the healthcare needs of Virginians for 90 years. We have offices throughout the state, including Richmond, Norfolk, Roanoke, and Northern Virginia.

Anthem is an independent licensee of the Blue Cross and Blue Shield Association serving members in 14 states. With over 7,500 employees in VA and more than 101,000 employees nationwide, we are able to leverage national networks and resources while still providing strong local presence and support. That's good news for the 48 million members we serve.

serving VA for
90+
years

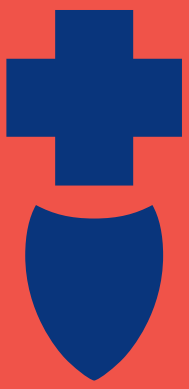
members in
14
states

7,500+
employees in VA

101,000+
employees nationwide

48,000M
national Anthem members

1.7M doctors
across our national network



Welcome to Anthem KeyCare benefits

We're glad you're taking time to check out all that Anthem KeyCare has to offer. We are excited for the opportunity to provide health plan coverage to Henrico County General Government and Public Schools for the upcoming year. Choosing your benefits is an important decision and this booklet is designed to help. It's a snapshot of the benefits that come with Anthem KeyCare coverage. It shows what's available to you, what you receive with each benefit and how the plans work.

Explore the Anthem KeyCare membership advantage

We know you're busy. That's why we've made it easier to explore the advantages of being an Anthem KeyCare member:

- There's a good chance your doctor is part of Anthem KeyCare's network. To find out, go to **anthem.com** and search using the Find a Doctor tool.
- You have more than access to coverage. You also receive tools, resources, and guidance that may help you reach your personal, healthy best.
- Our website — **anthem.com** — has the answers you need. Go to **anthem.com** for answers to your claims questions and find detailed health benefit information.
- This booklet goes into all this. Please look over the information, and keep this booklet.

Registering on anthem.com is step one

Once you receive your ID card, you can register online in five minutes. After you register at **anthem.com**, you can use decision-making tools, health information, and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, and learn about doctors and hospitals.

- Go to **anthem.com**
- Select the **Register now** link and follow the instructions to create your user name and password.

The out-of-area PPO plan is available for employees and early retirees whose primary residence is outside of the Anthem HealthKeepers service area.

This guide can help you choose your benefits with confidence. If you have questions, your benefits manager will be happy to answer them. Thanks for considering Anthem KeyCare.

Henrico County General Government and Public Schools KeyCare PPO Plan important contact information

Important phone numbers

Member Services
844-721-0404 Eastern Standard Time
Monday to Friday, 8 a.m. to 6 p.m.

24/7 NurseLine
800-700-9184

BlueCard Access
800-810-2583

Member Pharmacy Services
833-262-1729

Mail Order Pharmacy Services
833-396-0309

Provider Services
(in case your doctor needs to contact Anthem to coordinate a service for you or obtain an authorization)
800-676-2583

Pre-Authorization
844-928-3682

Mental Health Services
855-873-4932

Blue View Vision
Call Member Services at 833-630-6742

Visit us at anthem.com

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Your health benefit

Your member ID card

Your Member ID card is the first step in using your healthcare benefits. Once Anthem receives your information from Henrico County General Government and Public Schools, you will receive an ID card. Members will usually receive their ID cards within 10 working days after Anthem has processed the enrollment/change.

The ID card lists the subscriber's member number, the group number, and the date the benefits described on the card begin for that member. Each covered family member will receive a separate ID card.

The member number is a system-generated number. Please review the ID card to make sure the information is correct. If information is incorrect, contact Henrico County General Government and Public Schools.

If you need additional cards, you can print them at your convenience by logging in to **anthem.com**. You may also contact Member Services at **833-630-6742** to request a card. It is important that you present your ID card prior to receiving medical care.

Stay on top of your health

Use your preventive care benefits

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 are right for you, talk to your doctor.

Preventive care vs. diagnostic care: Knowing the difference

Preventive care helps protect you from getting sick. If your doctor recommends services when 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 and drug misuse: related screening and behavioral counseling
- Anxiety, depression, and suicide risk screenings
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet and physical activity
- High blood pressure (hypertension) screening
- 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 (exam of the large intestine), screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)[2]
- Diabetes screening (type 2)[3]
- Exercise interventions to prevent falls in adults over age 65
- 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 adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years[2]
- Obesity: related screening and counseling[3]
- Sexually transmitted infections: related screening and counseling
- Syphilis infection screening for persons who are at increased risk
- 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[6,7,8/9]
- Chlamydia and gonorrhea screening
- 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

continued »

Stay on top of your health *(continued)*

Use your preventive care benefits

- Human papillomavirus (HPV) screening[7]
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, HIV, healthy weight, preeclampsia, and depression[7]
- Urinary incontinence screening
- Well-woman visits

Immunizations:

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

Child preventive care

Preventive physical exams, screenings, and tests:

- Anemia screening
- Anxiety, depression, and suicide risk screenings
- Autism Spectrum Disorder (ASD) screening
- Blood pressure screening
- Cervical dysplasia (abnormal cell growth on the cervix) screening
- Cholesterol and lipid (fat) levels screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Hepatitis B screening
- HIV screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Ocular prophylaxis for Gonococcal Ophthalmia Neonatorium: Preventive medication: newborns
- 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
- Sudden cardiac arrest/death risk assessment
- Tobacco, alcohol, and drug use assessments
- Vision screening for those ages 6 months to 5 years

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Respiratory syncytial virus (RSV)
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- 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
- Have prescriptions, including for OTC items
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network

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[7,8]
- 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

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

- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for members ages 45 to 75
- 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)
- Preexposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDAapproved brand-name and generic OTC and prescription products, for members 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

If you'd like more help understanding your preventive care benefits, call the Member Services number on your health plan 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**.

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.

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

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

9 Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as apediatrician, 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.

Find a doctor online

We believe that finding a doctor online is one of the top reasons many of you visit our website. That's why we keep working on our Find a Doctor tool to make it better. Here's how you can receive information about doctors in your area.

For members

1. Visit **anthem.com** and log in.
2. Select the **Find Care** tool on the right side of the page.
3. Select the type of doctor you're looking for.
4. Select **Search**.

For non-members

5. Go to **anthem.com** to find a listing of available providers.
6. Select **Menu** and then choose **Find Care**.
7. Answer questions that can help us find find you the right plan and doctor in your plan.
8. Enter or select the plan/network.*
9. Select a type of provider, place or name.
10. Select **Search**.

To search for doctors, hospitals, and pharmacies from your mobile device, go to anthem.com. You can also download our free app from the App Store on your Apple or Android mobile device. Search Anthem Blue Cross and Blue Shield and download.

Sydney, Anthem's mobile app — your benefits at your fingertips

Using our mobile app can make it easier to manage your healthcare. You can do things like:

1. Find a doctor.
2. Receive your ID card.
3. Check your claims.
4. Estimate your costs.

To download the app:

1. Go to the App Store® or Google Play™ on your mobile device.
2. Search for **Sydney Anthem**.
3. Select the app and download for free.

If you are searching for a provider out of state, scroll down the Medical Plan Employer-sponsored options until you see National PPO / BlueCard PPO to insure the largest list of providers are given to you.

*For your plan, pick "Anthem KeyCare (PPO)".

Emergency and urgent care

Our plans provide coverage for medical emergencies, no matter where they occur. It's important for you to understand the difference between an emergency and an urgent situation.

If you are experiencing a medical emergency, get the care you need. Go to the nearest participating hospital emergency room (ER). Hospital ERs that are not in your plan's network should only be used if the delay receiving care from a participating ER could cause your condition to get worse.

If you are admitted to a non-participating hospital in an emergency, you must let us know within 48 hours or by the next working day if the 48-hour deadline falls on a weekend or legal holiday. An exception to this requirement is made if you are incapacitated and unable to contact us. In this case, you must make arrangements to notify us as soon as possible.

What is a medical emergency?

A medical emergency is the sudden onset of a medical condition, such as unusually severe symptoms. You should seek immediate medical attention if the condition could result in serious jeopardy to your mental or physical health, serious impairment of your bodily functions, serious dysfunction of of your bodily organs, or if pregnant, serious jeopardy to the health of the baby.

When to call your PCP before seeking care

If an emergency occurs and time permits or if you are not sure you are experiencing a medical emergency, call your PCP, even if you are on vacation. Your PCP's offi e may have a doctor on call 24 hours a day, seven days a week.

Where to go for care

If you have an unexpected illness or injury while in the service area that requires immediate treatment, call your PCP. Your PCP may be able to see you in the offi e or suggest temporary measures to take before an office visit. If this is not possible, your PCP may advise you to visit one of our participating urgent care centers. You can also call the 24/7 toll-free NurseLine to speak with a registered nurse who will advise you on where to go.

Convenient care for members

Members can use a Patient First physician as their PCP. You will pay the PCP copayment when you receive care from a Patient First physician. This gives you greater flexibility to access primary care services in the Richmond area.

When out of the service area

If you have an unexpected illness not usually associated with urgent care while you are out of the service area, we may pay for treatment at an urgent care facility. For urgent care outside the service area, call the number on your member ID card.

continued **»**

Emergency and urgent care *(continued)*

Medical emergency examples

Other examples of a medical emergency include:

- Severe or unusual bleeding
- Trouble breathing
- Chest pain
- Choking
- Suspected poisoning
- Convulsions or seizures
- Broken bone
- Fainting or unconsciousness
- Vaginal bleeding in pregnancy

What is not a medical emergency?

As a single symptom, these are not emergencies. Call your PCP for these problems:

- Coughing
- Diarrhea
- Sore throat
- Colds
- Stomach ache
- Rashes
- Vomiting
- Earache
- Toothache
- Pink eye
- Mild fever
- Bruises

Note: your claim may be denied if you go to the emergency room when it is not a true emergency.

Urgent care examples

When a minor illness or injury occurs unexpectedly and your doctor's offi e is closed, consider using an urgent care center. Other examples of urgent care are:

- Sprains
- Non-severe bleeding
- General cuts that require stitches

24/7 Nurseline

Round the clock access to health information can help give you peace of mind and your physical well-being. That's why we have nurse coaches ready to speak with you about your general health issues. Just call the 24/7 toll-free Nurseline to get answers to questions like these:

Can the problem be treated at home?

Do you need to see your doctor?

Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. It can also safeguard your health and the health of your family.

To reach the 24/7 Nurseline, call **800-337-4770**.

Coverage while traveling

Whether you're traveling on business, away for fun, or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting the Anthem network with those of other Blue Cross and Blue Shield companies across the US. You'll have access to medical care most wherever you're staying.

Receiving medical care away from home is as convenient as accessing the local network:

1. Find a provider from the BlueCard listing. You can search online at **anthem.com** or call the Member Services number on the back of your member ID card. You can also call BlueCard Access at **800-810-BLUE (2583)**.
2. Call Anthem Member Services to verify your coverage.
3. Show your ID card at the time of service.
4. As an Anthem KeyCare member, you are covered for office visits and other services at the same cost as out-of-network visits when you are at home.

You pay the same with a Blue Cross and Blue Shield provider as you would an Anthem network provider. Plus the provider will file your claims for you. Anthem will still mail your explanation of benefits so you can double-check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 48 hours or as soon as reasonably possible.

Make the most of your benefits with these smart tips

Action Step #1: Ask about other facilities that can perform certain procedures

Since hospitals have higher overhead costs, their rates are usually higher for inpatient and outpatient services. If you can have your service or procedure done at a doctor's offi e, surgery center, or free-standing radiology center instead, you might have lower out-of-pocket costs. For many services at these places, you'll probably only pay a copayment (a set amount) instead of a coinsurance (a percentage).

Action Step #2: Ask about your options for radiology services

The cost for radiology services can vary depending on where they're done. For example, in one offi e you may only be charged a copayment, while another facility may require a coinsurance. So, if it's not an emergency, be sure to check with your doctor about your radiology options.

Action Step #3: Comparison shop with the Estimate Your Cost tool

Know how much a procedure will cost before having it done. With the Estimate Your Cost tool, you get side-by-side cost estimates at area facilities for more than 400 procedures, such as knee replacement, maternity services and tonsillectomy. You can view our demo at **anthem.com**.

Action Step #4: Avoid using emergency rooms for conditions that aren't life threatening

Services cost more in the ER than they would in your primary care or family doctor's offi e. For minor cuts and sprains, ear infections, urinary tract infections, and bronchitis, you would save money by avoiding the ER. If it's not life threatening, consider making an appointment instead. You may also save time; waiting in the ER takes longer than waiting in your doctor's lobby.

Small things add up.

People want to know how to get the absolute most from their benefits. They're experts at finding extra dollars in the corners and corridors of the healthcare system. They're also skilled at using plan features to their advantage. You too can be one of these in-the-know experts. Here are their secrets.

Talk to a doctor whenever you need care — 365 days a year. LiveHealth Online uses two-way video chat to connect you with doctors over the Internet. You don't need to schedule an appointment, drive to the doctor's offi e, and wait for your appointment. You don't even have to leave your home or offi e. Doctors can answer your questions, make a diagnosis, and even prescribe basic medications. Go to **LiveHealthOnline.com** and set up your personal account, or access through your Sydney Preferred mobile app.

Action Step #5: Take advantage of those preventive benefits

Immunizations, mammograms, and annual checkups help you stay healthy. That's why preventive services like these are covered by your plan. Don't forget to use them. They can help prevent costly chronic conditions such as diabetes and high blood pressure, which mean more services, more doctor visits, and more money out of your pocket. Your entire collection of wellness benefits can be found at **anthem.com**, or by calling the Member Services number on your ID card.

Action Step #6: Keep an eye on your EOB

You'll receive an Explanation of Benefits (EOB) whenever you use your benefits and you owe a cost share. It's like your personal claim and coverage report. When you get one, make sure it's accurate and includes only the services you received. If you're ever not sure about a charge, call Member Services and we can help clear things up.

Action Step #7: Surround yourself with support from Anthem's Health and Wellness Programs

Anthem has many Health and Wellness Programs that support you with the help you need to live healthier, feel better, and save money. Personalized information, 24/7 access to a nurse, and trained health management professionals help you navigate the healthcare system and use your benefits wisely. It's also part of your plan at no extra cost. Start by taking a MyHealth Assessment at **anthem.com**, which can analyze the choices you make and provide suggestions for the steps you can take.

Action Step #8: Use doctors and hospitals in your plan's network

They'll cost less than providers that aren't in your plan's network. Anthem contracts with doctors and hospitals to offer services for our members at a discounted rate. These "in-network" doctors agree to accept this discounted rate as payment in full and can't balance-bill you. Doctors who aren't contracted with Anthem are considered "out-of-network." If you visit an out-of-network doctor, your out-of- pocket costs may be higher because the discount won't apply and they can balance-bill you for the difference. Don't assume that all doctors and hospitals are in our network. Before seeking services, check our Find a Doctor tool at **anthem.com**; if they're not on Find a Doctor, most likely they're out-of-network. You can also call your doctor or the Member Services number on your ID card.

Action Step #9: Get health tips from anthem.com

At **anthem.com**, you'll find plenty of expert information to help you stay on top of your healthcare options, costs and ways to improve your health. Explore the website to learn more. You can also call Member Services for more help.

Register today at anthem.com

From your computer:

- Go to **anthem.com** and select **Register Now**
- Provide the personal information requested
- Create a username and password
- Set your email preferences
- Select **Submit**

From your mobile device:

- Download the free Anthem Sydney mobile app and select **Register Now**
- Confirm your identity
- Create a username and password
- Set your email preferences
- Confirm and select **Register**

Anthem KeyCare PPO Plan

You have the power to take charge of your health. That's why we build our health plans with options, resources, and support to help you make decisions. This is a quick overview of how your plan works.

Anthem KeyCare is a PPO plan, which means you're free to choose your doctor without referrals. In-network care will usually cost less than out-of-network care. The network includes most doctors and hospitals across the nation to help you find plenty of choices.

As an Anthem member, you have access to several online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health, and your budget.

With no primary doctor requirement and no referrals, you're free to make your own decisions about your healthcare.

Anthem KeyCare PPO at a glance

- **Primary care physicians (PCPs):** Not required
  You can make your own decisions about your doctors, your care and your costs.
- **Referrals:** Not needed.
- **Claim forms:** No claim forms to submit when using network providers.
- **Out-of-network benefits:** Available, but at lower coverage levels than in-network.
  We've negotiated special rates with our network doctors and hospitals on behalf of our members.
  By staying in-network, you can take advantage of these rates and receive higher levels of coverage. -
- **Out-of-pocket:** This is the amount you'll pay for the cost of covered services.

You can see what services cost before your visit

Through **anthem.com**, you can estimate the costs for inpatient and outpatient services, and doctor visits.

You're covered whenever you travel

If you're traveling in the US or out of the country, your coverage travels with you. If you need emergency, urgent, or approved follow-up care, you have three options. Go to **anthem.com**, call BlueCard® PPO Access at **800-810-2583**, or call the Member Services number on your member ID card.

You have more than a health plan

You get programs to actually help you manage your health. Wellness tools, health and wellness management programs, and family and home special offers are all available through **anthem.com**. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your benefits summary contains the details.

Your benefits

Anthem

Henrico County General Government and Public Schools Anthem KeyCare PPO Plan

Covered medical benefits	Cost if you use an in-network provider	Cost if you use a non-network provider
Overall deductible Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.	**$400 person / $800 family**	**$1,000 person / $2,000 family**
Overall out-of-pocket limit	**$2,500 person / $5,000 family**	**$2,500 person / $5,000 family**
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-network and non-network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor visits (virtual and office) You are encouraged to select a Primary Care Physician (PCP).		
Virtual Visits from online provider LiveHealth Online for primary care, urgent/acute medical and mental health and substance abuse care via **www.livehealthonline.com** are covered at $0 copay per visit medical deductible does not apply.		
Vera Whole Health Centers for medical and mental/behavioral health exams covered at $0 cost share, deductible does not apply.		
Primary care (PCP) and mental health and substance abuse care Virtual and office	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Specialist care Virtual and office	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Other practitioner visits		
Routine maternity care Prenatal and postnatal	**$50** copay per pregnancy deductible does not apply	**30%** coinsurance after deductible is met
Retail health clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Manipulation therapy Coverage is limited to 30 visits per benefit period.	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Other services in an office		
Allergy testing	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Prescription drugs Dispensed in the office	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Surgery	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Preventive care / screenings / immunizations	**No charge**	**30%** coinsurance after deductible is met
Preventive care for chronic conditions Per IRS guidelines	**No charge**	**30%** coinsurance after deductible is met
Diagnostic services		
Lab		
Office	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Preferred reference lab	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met

Diagnostic services *(continued)*		
X-ray		
Office	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Advanced diagnostic imaging (for example: MRI, PET and CAT scans)		
Office	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Emergency and urgent care		
Urgent care	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Emergency room facility services	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Emergency room doctor and other services	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Ambulance	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Outpatient mental health and substance abuse care at a facility		
Facility fees	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Doctor services	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Outpatient surgery		
Facility fees		
Hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Ambulatory surgical center	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Doctor and other services		
Hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Hospital (including maternity, mental health and substance abuse)		
Facility fees	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Physician and other services including surgeon fees	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Home health care Coverage is limited to 90 visits per benefit period.	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Rehabilitation and habilitation services (including physical, occupational and speech therapies) Coverage for physical, occupational and speech therapies is unlimited.		
Office	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Pulmonary rehabilitation Office and outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Cardiac rehabilitation Office and outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Dialysis/Hemodialysis Office and outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met

Chemo/Radiation therapy Office and outpatient hospital	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Skilled nursing care (facility) Coverage is limited to 100 days per benefit period.	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Inpatient hospice	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Durable medical equipment	**20%** coinsurance after deductible is met	**30%** coinsurance after deductible is met
Prosthetic devices Coverage for wigs is limited to 1 per benefit period for any covered medical diagnosis that causes hair loss and for the diagnosis of alopecia.	**20%** coinsurance after deductible is met	**30%** coinsurance after 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 / $150 family**	**$150 person / $150 family**
Prescription drug coverage **Network: Base network**		
Drug list: **National direct** – Drugs not included on the drug list will not be covered. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.		
Day supply limits: **Retail Pharmacy** 30 day supply (cost shares noted below) **Retail 90 Pharmacy** 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). **Home Delivery Pharmacy** 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service. **Specialty Pharmacy** 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.		
Tier 1 — Typically generic	**$10 copay** per prescription, after pharmacy deductible is met (retail and home delivery)	**$10 copay** per prescription, after pharmacy deductible is met (retail) and NOT covered (home delivery)
Tier 2 — Typically preferred brand	**$30 copay** per prescription after Pharmacy deductible is met (retail) and **$60 copay** per prescription after Pharmacy deductible is met (home delivery)	**$30 copay** per prescription after Pharmacy deductible is met (retail) and NOT covered (home delivery)
Tier 3 — Typically non-preferred brand/specialty drugs	**$55 copay** per prescription after Pharmacy deductible is met (retail) and **$165 copay** per prescription after Pharmacy deductible is met (home delivery)	**$55 copay** per prescription after 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. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.		
Children's vision exam	**$15 copay**	**$30** allowance
Adult vision exam	**$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.

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

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

Prescription drug plan

Pharmacy network

Our prescription drug program manages more than 400 million prescriptions each year. With a broad retail pharmacy network, home delivery and a specialty unit that dispenses high-cost, biotech therapies, our comprehensive approach helps you manage your pharmacy benefits.

Your plan has a tiered drug list/formulary, or list of covered medications, which assigns drugs to specific tiers based on cost. Tier 1 drugs have the most affordable copay. Tier 2 drugs cost slightly more, and Tier 3 drugs have the highest copay amounts.

Generic medications are mandatory

Prescription drugs will always be dispensed as ordered by your physician. If your physician requires that you take the brand name drug instead of the generic drug, it will be covered at the applicable copayment. However, if you elect the brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

Brand and generic drugs have the same active ingredient, strength, and dose. And generics must meet the same high standards for safety, quality and purity.

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

Talk to your doctor to see if a generic is right for you. Don't switch or stop taking a drug until you talk to your doctor.

Why generics cost less

Developing a new drug is expensive. When a company creates a new drug, it receives a patent for up to 20 years. That means only the company that created it can sell it during that time. Once the patent expires, other companies can make copies of the same drug. These companies avoid the high costs of developing the drug — and that helps lower the price for you.

Retail pharmacy network

Our network includes nearly 70,000 pharmacies across the country. That means you have convenient access to your prescriptions wherever you are — at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

To make sure your pharmacy's in our network, visit **anthem.com** and scroll down to the **Manage your Prescriptions** link and log in to access the Pharmacy Overview page.

Choosing a non-network pharmacy means you'll pay the full cost of your drug. Then, you may submit a prescription drug claim form to be repaid. To access the form, visit **anthem.com** and select **Forms** from the main menu.

Retail 90 pharmacy

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

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

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

Note about your pharmacy information on the web:
CarelonRx, an Anthem company, manages the operations of your drug plan.
To access your pharmacy information, go to **anthem.com**.

Home Delivery Pharmacy

Home delivery is for people who take medications on an ongoing basis. The Home Delivery Pharmacy, managed by CarelonRx, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Getting started with home delivery
You can order online, through the Sydney mobile app, by phone, or fax. Your order should arrive within 14 days from the date your order is received.

By fax: Have your doctor fax your prescription and plan ID card information to **833-389-4172**. It must be faxed directly from your doctor's offi e. If there is a question about your prescription, the pharmacy will contact your doctor.

Ordering refills

With home delivery, you don't have to worry about running out of medication. That's because the pharmacy will let you know when it's time to order refills. You can also enroll in Automatic Refills. You can easily order by phone, through the Sydney mobile app, or online:

By phone: Have your prescription label and credit card ready. Call **833-396-0309** and select **Automated Refill Order Line** option from the menu. Or press zero to speak with a patient care advocate. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

Through Sydney mobile app: Visit Prescriptions

Online: Visit **anthem.com**.

continued **»**

Prescription drug plan *(continued)*

Specialty pharmacy

CarelonRx provides support and medicine for people with complex, long-term conditions. They include (but are not limited to) long-term conditions such as inflammatory conditions, diabetes, cancer, HIV, and Hepatitis C.

You don't have to manage your health condition by yourself. Specialty pharmacy experts can help you get the best results from your treatments.

- Pharmacists can tell you more about your condition, how your drugs work, and the side effects. They can also answer urgent drug questions after hours.
- Nurses are available 24/7 to help you stay on track with your medicine. They'll make sure you take it just how the doctor wants. They will also help you with side effects.
- Care coordinators can help answer questions about insurance, paying for your drugs, and getting refills.

Ordering specialty drugs

You can place your first order by phone or fax:

- **By phone:** Call **833-262-1726**, Monday to Friday, 8 a.m. to 11 p.m. and Saturday 8 a.m. to 5 p.m., Eastern time. A patient care advocate will help you get started.
- **By fax** *(existing medications only)***:** Ask your doctor to fax your prescription and a copy of your ID card to **833-263-2871**.

To order refills online: visit **anthem.com**.

- Scroll down to the **Manage your Prescriptions** link and login to access our Pharmacy Overview page.
- Select the **Specialty Pharmacy Resources** link. You will be directed to the Express Scripts website.
- Select the **Learn More About Specialty Pharmacies** link to access a list of FAQs, including how to start using our exclusive specialty pharmacy.

Drug list

A drug list (or a formulary) is a list of prescription drugs covered by your plan and approved by the US Food and Drug Administration (FDA). It's made up of hundreds of brand and generic drugs.

An independent group of doctors, pharmacists, and other healthcare professionals review new and existing drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

You can check if medications you take are in your drug list at **anthem.com/nationaldirect3tier**. For a more detailed list, log in at **anthem.com**. If a medication is not on the list, there are other high-quality, cost-effective choices, called preferred alternatives, that are. Medications not included on the National Direct Drug List, along with their preferred alternatives can be found at **ENG_ABS National Direct Drug List-10.1 (anthem.com)**.

If you don't have access to a computer, you can check the status of a drug by calling Member Services at the phone number on your plan ID card.

Smoking cessation drug coverage

Your plan covers 100% of the cost for certain FDA-approved prescription and over-the-counter (OTC) products to help you quit smoking. You will need to obtain a prescription from your doctor for each product, including OTCs.

When you fill the prescription at a retail pharmacy, you need to show proof that you're at least 18 years old. If you're under 18, you may need to speak with your doctor to receive the OTC product. By law, they can only be sold to people over 18.

Over-the-counter prescription drugs

The Plan also covers select over-the-counter (OTC) drugs at the Tier 1 copay, provided you obtain a prescription from your Physician. A 30-day supply is available per prescription at local participating retail pharmacies only.

Covered OTC medications include:

- Esomeprazole Magnesium (generic equivalents of Nexium)
- Lansoprazole (generic equivalents of Prevacid OTC®)
- Omeprazole (generic equivalents of Prilosec OTC®/Zegerid OTC™)
- Cetirizine (generic equivalents of Zyrtec OTC®)
- Fexofenadine (generic equivalents of Allegra OTC®)
- Loratadine (generic equivalents of Claritin OTC®)
- Polyethylene Glycol (generic equivalents of Miralax; Glycolax)
- Alaway™
- Zaditor®
- Miralax OTC®

The following OTC items are also covered at 100% when you present a prescription from your doctor at an in-network pharmacy:

- Iron supplements for children 0-12 months
- Fluoride supplements for children from birth through six years old
- Folic acid for women 55 years old or younger
- Aspirin for men between age 45-79
- Aspirin for women between age 55-79
- Vitamin D for women over 65

Prior authorization

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

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

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

The National Drug List also includes this information. To view it, visit: **anthem.com**.

Tips for understanding your coverage

Knowing the plan you have selected can make all the difference in getting the most value from your Anthem coverage. Here are tips to keep in mind when seeking services.

Services that require advance reviews

While you can see a doctor or go to a hospital in your plan's network, there may be instances in which a test or procedure your doctor wants you to have may not be covered. To help you minimize unanticipated costs from a non-covered service, we work with our in-network providers to make sure that certain services go through an advance review process first. This way, you'll know upfront whether the service is going to be covered.

Balance billing

In other situations, such as an emergency, getting the care you need is the first priority. During these times, if you receive care from hospitals and/or providers who have not contracted with us, they can charge whatever they want for their services. If what they charge is more than providers in our network have agreed to accept for the same service, you can be billed for the difference. This is called “balance billing.”

The best way to avoid balance billing is to:

- Use in-network doctors, hospital and other providers, including labs and x-ray facilities;
- Know what services are covered by your health plan; and
- Make sure to get prior authorization for a medical service, if required.

The exception to balance billing are those provisions of the Consolidated Appropriations Act of 2021 (CAA). The CAA is a federal law that includes the No Surprises Act as well as the Provider transparency requirements.

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Service provided by Out-of-Network Providers:
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services





Ins and outs of coverage

The ins and outs of coverage

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

But part of your decision in choosing a plan also requires understanding:

- Who can be enrolled
- How coverage changes are handled
- What is not covered by your plan
- How your plan works with other coverage

Who can be enrolled

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- Your spouse
- Your children until reaching age 26, including a newborn, biological child, adopted child, child placed with you for adoption; see the Plan Document details.

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

Certain 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 reached age 26.

Your Anthem KeyCare plan can be:

Renewed	Cancelled	When ...
●		You maintain your eligibility for coverage with your employer, pay your required portion of the healthcare premium, and do not commit fraud or misrepresent yourself.
	●	You purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	●	You lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card, or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.

Special enrollment periods

Typically you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is 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. There may be instances in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse, or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage. You must ask to be enrolled within 60 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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 60 days after the marriage, birth, adoption, or placement for adoption. If you 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, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your benefits offi e.

Members will need to notify their benefits offi e if a dependent loses eligibility for coverage, such as a former spouse at divorce, or a child over age 26.

continued **»**

The ins and outs of coverage *(continued)*

When you're covered by multiple plans

If you're covered by more than one health plan, our Coordination of Benefits (COB) program helps ensure you receive the benefits due and avoid overpayment by either carrier. Up-to-date, accurate information is the key to our Coordination of Benefits program, you can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

If you are covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay a claim and provide reimbursement according to plan allowances; the secondary carrier then provides reimbursement, if applicable, for remaining available benefits.

How benefits apply when Medicare-eligible

Certain people under age 65 are eligible for Medicare in addition to 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	Anthem KeyCare	Medicare is primary
Is a person who 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 less 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 less than 100 participants		●
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to 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		●

Recovery of overpayments

If healthcare benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover overpayment from:

- Any person to or for whom the overpayments were made;
- Any healthcare company; and
- Another organization.

What's not covered (exclusions)

When it comes to your health, you're the final decision maker about what services you need to receive and where you should get them from. To keep the cost of healthcare as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered. Refer to Evidence of Coverage for complete list.

Acupuncture unless otherwise specified

Biofeedback therapy

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

Cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

Dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem. Other dental services that will not be covered by your plan including the following as listed below:

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

continued **»**

The ins and outs of coverage *(continued)*

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

Experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. This will not prevent a member from being able to appeal Anthem's decision that a service is not experimental/investigative.

Family planning

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

Services for palliative or cosmetic **foot** care

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

Gene therapy as well as drugs, procedures, healthcare services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Experimental or not?

Many of the Anthem medical directors and staff actively participate in a number of national healthcare committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

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

Services for surgical treatments of **gynecomastia** for cosmetic purposes

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

Hearing care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

Home care services

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

Hospital services

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

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

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

- Exercise equipment
- Air conditioners, dehumidifiers, humidifiers, and purifiers
- Hypoallergenic bed linens
- Whirlpool baths
- Handrails, ramps, elevators, and stair glides
- Telephones
- Adjustments made to a vehicle
- Foot orthotics
- Changes made to a home or place of business
- Repair or replacement of equipment you lose or damage through neglect

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

Mental health and substance abuse

- Inpatient stays for environmental changes
- Cognitive rehabilitation therapy
- Educational therapy
- Vocational and recreational activities
- Coma stimulation therapy
- Services for sexual dysfunction
- Treatment of social maladjustment without signs of a psychiatric disorder
- Remedial or special education services
- Inpatient mental health treatments that meet the following criteria:
  - More than two hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital
  - Group psychotherapy when there are more than eight patients with a single therapist
  - Group psychotherapy when there are more than 12 patients with two therapists
  - More than 12 convulsive therapy treatments during a single admission
  - Psychotherapy provided on the same day of convulsive therapy

Non-medically necessary services and supplies as determined by Anthem at its sole discretion. Notwithstanding this exclusion, all preventive care and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on a day of inpatient care that is determined by Anthem to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist, or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when such pathologist, radiologist, or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal Anthem's decision that a service is not medically necessary.

Nutritional counseling and related services, as specifically provided by the health plan or except when provided as part of diabetes education, for treatment of an eating disorder, or when received as part of a covered preventive care visit.

Nutritional and/or dietary supplements, except as specifically listed in this enrollment brochure or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that

can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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

Organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of United States medical teaching colleges. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

Paternity testing

Prescription drug benefits received from a retail or home delivery (mail order) pharmacy. This exclusion does not apply to prescription medications for palliative care and pain management provided as part of hospice care services and prescription drugs provided through clinical trials for cancer.

Private duty nurses in the inpatient setting

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

Services or supplies or devices

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

continued »

The ins and outs of coverage *(continued)*

Services or supplies if provided or available to a member:

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

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

- Amounts above the allowable charge for a service
- Self-administered services or self care including self-administered injections
- Self-help training
- Neurofeedback, and related diagnostic tests

Services or supplies primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered preventive care visit or screening

Sexual dysfunction (male and female sexual problems) services or supplies, including medical and mental health services

Skilled nursing facility stays

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

Smoking cessation programs not affiliated with us

Spinal manipulation and manual medical therapy services for an illness or injury other than musculoskeletal conditions

Telemedicine

- Non-interactive telemedicine services such as, audio only telephone conversations, electronic mail message, facsimile transmissions, or online questionnaire.

Therapies

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

Services for treatment of varicose veins or telangiectatic dermal **veins** (spider veins) by all methods (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes

Vision services

- Vision services or supplies unless needed due to eye surgery and accidental injury
- Routine vision care and materials
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness, and/or astigmatism. This type of surgery includes keratoplasty and lasik procedure;
- Services for vision training and orthoptics
- Tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- Sunglasses or safety glasses and accompanying frames
- Non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- Lost or broken lenses or frames
- Cosmetic lens options that are not specifically listed in the Summary of Benefits
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or government entity
- Other vision services not specifically listed as covered

Weight loss programs whether or not they are pursued under medical or physician supervision, unless specifi ally listed as covered. This exclusion includes, but is not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss, etc.) and fasting programs.

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





Additional benefits

Blue View Vision℠

Vision care is not just for eyeglass wearers. Routine eye visits are important for everyone in preventing eyesight damage. Eye exams can also help detect other health problems. Blue View Vision exists so you can receive the vision care you need while still staying on budget.

Advantages of Anthem Blue View Vision:

- **You have access to eye doctors close to you.** Blue View Vision has 50,000 eye doctors and locations in its network. If you don't already have a favorite, you can quickly find one. Plus, many retail locations, like LensCrafters®, Target® Optical, and Pearle Vision® are covered by the plan. You can find a Blue View Vision provider at **anthem.com**.
- **You can get an eye exam every year.** Blue View Vision helps pay for eye exams annually.
- **Not many plans are this convenient.** Just schedule an appointment with a network provider and present your member ID card when you arrive. The doctor's office staff will take care of the rest.
- **You save even more with additional discounts.** If you want a frame that costs more than your plan allows, you can save 20% off the balance. If you want spare glasses, contact lenses, or prescription sunglasses, you can save 15 to 40%. Your additional discounts are unlimited — even after your vision care benefits have exhausted.

What happens if you use an eye professional not in the network?

You're still covered. You'll be asked to pay the full cost for services at the time of your appointment. When you mail in your receipt and other paperwork to Anthem, you'll get paid back for what the plan covers. To save the most money and have less hassle, try to use an eye doctor or retail location in the network.

This is a brief overview of your plan's features. Your summary of benefits contains the details.

Blue View Vision℠ exam only A15 plan

Anthem

WELCOME TO BLUE VIEW VISION

This summary outlines the basic components of your vision plan, including quick answers about what's covered and your discounts.

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 doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at **Glasses.com** and **ContactsDirect.com**. To locate a participating network eye care doctor or location, log in at **anthem.com**, or the Sydney app. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision. Just 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.

Your vision plan includes coverage for routine eye exams.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine eye exam			
Routine Eye Exam For members age 19 and older.	**$15 copay**	Reimbursed up To $30	Once every calendar year
Pediatric Routine Eye Exam For members up to age 19.	**$0 copay**	Reimbursed up To $30	Once every calendar year
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.			
Standard contact lens fitting	**$0 Copay**	Reimbursed up to $35	Once every calendar year
Premium contact lens fitting	10% off retail price, then apply $55 allowance	Reimbursed up to $35	

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 following page for further details.

OUT-OF-NETWORK

If you choose to, you may receive covered services outside of the Blue View Vision. 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 **1-866-723-0515** 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 1-866-723-0515. 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.

Blue View Vision℠ plan *(continued)*

Anthem

EXCLUSIONS & LIMITATIONS (not a comprehensive list — please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Sunglasses. Plano sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Not Specifically Listed. Services not specifically listed in this plan as covered services.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY (Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage.)		**IN-NETWORK MEMBER COST** (after any applicable copay)
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[1]	35% of retail price
Eyeglass lenses Standard plastic material	◦ When purchased as part of a complete pair of eyeglasses[1]	
	– Single Vision	$50
	– Bifocal Vision	$70
	– Trifocal Vision	$105
Eyeglass lens options and upgrades When purchasing a complete pair of eyeglasses[1] (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 eyeglasses lenses.	◦ UV coating	$15
	◦ Tint (solid and gradient)	$15
	◦ Standard scratch-resistant coating	$15
	◦ Standard polycarbonate	$40
	◦ Standard anti-reflective coating	$45
	◦ Standard progressive lenses (add-on- to bifocal)	$65
	◦ Other add-ons (i.e. high index lenses, anti-fogcoating)	20% of retail price
Conventional contact lenses (non-disposable type)	◦ Discount applies to materials only	15% of retail price

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 this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations.

Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK · LENSCRAFTERS · PEARLE VISION EST. 1961 · TARGET OPTICAL · GLASSES.COM · contactsdirect · 1800contacts · Ray-Ban · OAKLEY

Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at anthem.com, select discounts, then Vision, Hearing & Dental.

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

* Discounts cannot be used in conjunction with your covered benefits.

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Health, wellness and Anthem advantages

Make the most of your health plan

anthem.com

Clear. Intutive. Convenient.

Save money and live better with tools that keep you informed, in control, and at your healthy best.

Health and wellness

Now it's easier than ever to improve your health and well-being. Visit **anthem.com** and login to your account to have access to an array of innovative tools to help you manage your health and achieve your goals.

Health Assessment

Your first step toward a healthier lifestyle

Gain personal insights into your current health, your health risks, and what you can do to enjoy a healthier life. You complete a confidential assessment of your health and healthcare status, then receive a health assessment score and risk profile based on your specific nswers. You also get tips and actions to help you improve your health.

To use the Health Assessment:

- Visit **anthem.com**
- Select **Health & Wellness**
- Select **Take my HA now**

Health Record

Your health history in one secure location

Keep your medical records organized, secure, and easily accessible for emergencies and everyday use. Enter your information, such as dates of immunizations, tests and screenings, prescription and over-the-counter drugs you take, and medical conditions. Print and share with your doctors to help avoid potential drug interactions and duplicative tests and procedures.

To use Health Record:

- Log in at **anthem.com**
- Select **Health & Wellness**
- Under Health Assessment, select **Start your Health Record**

LiveHealth Online

With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's offi e, and then wait for your appointment. You don't even have to leave your home or offi e. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of board-certified doctors.
- Private, secure, and convenient online visits.

Members who register pay the following:
$0 (deductible does not apply).

To enroll, download the app on your mobile device and complete the About You page, or sign up on your computer at livehealthonline.com.

LiveHealth Online Psychology
A convenient way to see a therapist or psychologist.

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

Make your first appointment — when it's convenient for you

- Use the app or go to **livehealthonline.com** and log in. Select **LiveHealth Online Psychology** and choose the therapist you'd like to see, or call LiveHealth Online at **844-784-8409** from 7 a.m. to 11 p.m. You'll get an email confirming your appointment.
- You pay the following:
  $0 (deductible does not apply).

Note: Appointments subject to availability of a therapist.

Special Offers
Discounts on health-related products and services

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids, and audiology services, fitness center memberships, and weight loss programs.

To access all discounts:

- Log in at **anthem.com**
- Select the **Discounts** tab

Patient Ratings & Reviews
Doctor recommendations from your peers

Choosing a doctor is one of the most important choices you make for your healthcare. When you find the right one, it can make all the difference in the world and lead to better care and better health. Use our improved Patient Ratings & Reviews tool to see ratings and comments from other patients who have seen a doctor. It can help you make the right choice for you.

Patient Ratings and reviews can be found on **anthem.com**. Choose Find a Doctor, search for a doctor, and see what ratings are available and what others have to say.

Not registered at anthem.com?
Sign up now for access to personalized service and resources. It's fast, convenient, and secure.

Health and wellness programs

The programs you read about here come with your health plan. There is no extra cost for them.

To learn more about these programs online, log in to **anthem.com** and select **MyHealth@Anthem**.

Take charge of your health and the choices you make

We all have different health needs. Maybe you're fit and want to stay that way. Maybe you're living with a chronic condition like asthma. No matter where you fall, our Health and Wellness programs are here to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, we can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

24/7 NurseLine

Within the emergency and urgent care section, we told you about the 24/7 NurseLine that comes with your plan to help you with healthcare decisions you need to make. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. It can also safeguard your health and the health of your family.

To reach 24/7 NurseLine, call 800-337-4770.

Maven

Maven offers 24/7 virtual support for you and your family. One integrated platform and care model across fertility, maternity, parenting, menopause, and pediatrics at no cost to you.

- Fertility and Family Building program supports all pathways to parenthood. Starting with those trying to conceive, through fertility treatment.
- Maternity and Newborn Care program offers personalized coaching and holistic support from pregnancy through 12 months postpartum, as well as for non-birthing partners, surrogates and those experiencing pregnancy loss.
- Parenting and Pediatrics offers parenting guidance and developmental health support for every family stage.
- Menopause and Midlife Health program supports people as they manage their symptoms and hormonal health for better long-term health.

MyHealth Advantage
MyHealth Advantage can keep you and your bank account healthier.

MyHealth Advantage connects your claims, doctor reports, personal health history, and other information for a bigger picture of your health. If we see things you can act on to help improve your health or save money, you'll receive a MyHealth Note — a confidential health summary. The program can help you keep health issues from developing or becoming serious. That means lower healthcare costs down the road.

MyHealth Notes are mailed to you, or you can read our suggestions on your iPhone or Android device by downloading the Anthem Sydney app. With this app, you have the option of getting personalized health messages on the go via the Secure Message Center.

Healthy Lifestyles

Healthy Lifestyles is a free online program that gives you support and rewards to help you stay healthy or get healthier. Whether you want to quit smoking, lose weight, eat right, exercise more, or manage stress, Healthy Lifestyles helps you to set goals, track your progress, and earn rewards. With Healthy Lifestyles, you can:

- Sign up for a program to quit smoking
- Use nutrition and fitness trackers
- Find healthy recipes
- Join community and online forums
- Receive discounts on massages, gym memberships, and spa services

To learn more, visit anthem.com.

Total Health Connections
With a dedicated advocate in your corner, healthcare is easier at every step

Total Health Connections is about making sure you and your family experience healthcare in a way that helps you feel confident, covered, and protected.

With Total Health Connections, you have your own personal health champion, called a family advocate. Your dedicated family advocate is here to help you and your family through unexpected emergencies and everyday health needs. They stay one step ahead, helping you get the care and support you need today and down the road — at no extra cost to you.

continued **»**

Health and wellness programs *(continued)*

Here's how you'll benefit:

A dedicated family advocate
Your family advocate is here to connect you with the right care at the right time with proactive, inclusive, and compassionate support. They can help you:

- Find top-quality doctors, specialists, and care facilities in your health plan and help schedule appointments.
- Stay on top of preventive care and manage chronic conditions.
- Understand your health plan and all the benefits available to you from your employer.
- Quickly get preapprovals for urgent medical needs, like surgery.
- Connect with our in-house clinical experts. These experts work with you and your doctor to create a personal care plan that supports your overall wellness and ongoing health needs.

A connected health record
You and your advocate, doctors, and pharmacist all have access to the most up-to-date information on your health in a single record. These real-time insights can help improve your care and may lower your healthcare costs over time.

Attention to your whole health
Your physical health impacts your overall well-being, yet it's just one piece of the puzzle. Whole health also includes your mental health, along with social and community needs. Your advocate helps you get the care you need in the way that works best for you. They can also connect you with community resources to help with food, child care, transportation, and other social, financial, or mental health concerns.

Everything you need, right on the app
The Sydney℠ Health mobile app gives you a quick way to:

- Chat with an advocate.
- Check costs and view your health plan details.
- Find additional benefits available through your employer.
- Use your digital ID card.
- Find local doctors in your plan.
- Find cost and quality information for doctors, facilities, and common procedures.
- Track your health goals and activity.
- Access virtual care through video visit or text chat.

Connect with your family advocate with a quick download of the Sydney Health mobile app from the App Store® or Google Play™.





Information you should know

Managing your care if you need to go to a hospital or get a specif c medical treatment

If you or a family member needs a certain type of medical care (such as surgery, a treatment done in a doctor's offi e, or physical therapy), you may want to know more about the following programs and definitions. They may help you better understand how your benefits work and how your health plan manages your care in these types of situations.

Utilization Management

Utilization Management (UM) is a program that is part of your health plan that lets us make sure you're getting the right care at the right time. Our UM program is made up of a team of licensed healthcare professionals such as nurses and doctors who do medical reviews. The UM review team goes over the information we have received from your doctor or other healthcare provider to see if a surgery, treatment, or other type of care that has been requested is medically needed. The UM review team checks to make sure that the treatment meets specific ules set by your health plan. After reviewing the records and information, the surgery or treatment will be approved (covered) or denied (not covered) and the UM review team will let you and your doctor know as soon as possible.

Medical reviews like this can be done before, during, and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before medical care is given)
A prospective review is done before a member goes to the hospital or has another type of service or treatment.

Here are other types of medical needs you may have that might call for a prospective review:

- To go to (and/or stay at) a hospital
- An outpatient procedure (you can go home the same day)
- Tests done to try to find the cause of an illness such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans
- A certain type of outpatient therapy such as physical therapy or emotional health counseling
- Durable medical equipment (DME) which means wheelchairs, walkers, crutches, and hospital beds

The concurrent review (done during medical care and recovery)
A concurrent review is done at the time you are in the hospital or released and need more care related to the hospital stay. This could mean services or treatment done in a doctor's office, regular offi e visits, physical or emotional therapy, home healthcare, durable medical equipment (see above), staying in a nursing home, and receiving emotional healthcare. The UM review team looks at your medical information at the time of the review to see if the treatment is medically needed.

The retrospective or post-service review (done after medical care is given)
A retrospective review is done when you have already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at your medical information that the doctor or provider had at the time the medical care was given. They can then see if the treatment was medically needed.

Case Management

Case managers are licensed healthcare professionals who work with you and your doctor to help you learn about and manage your health conditions, and help you better understand your health benefits.

Your rights and responsibilities as an Anthem KeyCare member

As an Anthem KeyCare member, you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared, and how you work with us and your doctors. Knowing these rights and responsibilities helps you know what you can expect from your overall healthcare experience and become a smarter healthcare consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all healthcare options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your healthcare.
- Be treated with respect, dignity, and the right to privacy.
- Have privacy when it comes to your personal health information, as long as it follows state and federal laws and our privacy rules.
- Get information about our company, services, network of doctors, and other healthcare providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about the rules of your healthcare plan and the way your plan works.
- Make a complaint or file an appeal about:
  - Your healthcare plan
  - Care you receive
  - A covered service or benefit ruling that your healthcare plan makes
- Say no to care, for a condition, sickness, or disease, without it affecting the care you may receive in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Receive all of the most up-to-date information about the cause of your illness, your treatment, and what may result from that illness or treatment from a doctor or other healthcare professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

You have the responsibility to:

- Keep all scheduled appointments with your healthcare providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other healthcare professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or healthcare professionals.
- Tell your doctors or other healthcare professionals if you don't understand the care you're receiving or what they want you to do as part of your care plan.
- Follow all healthcare plan rules and policies.
- Let our Member Services department know if you have changes to your name, address or family members covered under your plan.
- Give us, your doctors and other healthcare professionals the information needed to help you receive the best possible care and all the benefits you are entitled to. This may include information about other healthcare plans and insurance benefits you have in addition to your coverage with us.

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy.

If you ever need a benefit-covered mastectomy, we hope it will give you peace of mind to know that your Anthem benefits 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.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. We don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

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

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for healthcare you receive through your plan. We keep information about your premium and deductible payments. We may give information to a doctor's offi e to confirm your benefits.

For healthcare operations: We use and share PHI for our healthcare operations. We may use PHI to review the quality of care and services you receive. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a healthcare provider such as your doctor or a hospital. We may share PHI with your healthcare provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know 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 products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend, or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend, or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors, or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the US Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence, or other crimes. PHI can also be shared as required by law.

We may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for a purpose not stated in this notice. You may take away this OK, in writing. We will then stop using your PHI for that purpose. If we have already used or shared your PHI based on your OK, we cannot undo the actions we took before you told us to stop.

Genetic information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

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Important legal information you should take time to read *(continued)*

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment, or healthcare operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. You can also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Member Services at the phone number printed on your ID card to use these rights. They can give you the address to send the request. They can also give you forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Ways we keep your PHI safe include offi es that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if a state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Offi e for Civil Rights in the US Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Member Services at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and changes

You have the right to receive a new copy of this notice. Even if you have agreed to get this notice by electronic means, you still have the right to 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 PHI we may receive in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about changes.

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Important legal information you should take time to read *(continued)*

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identific cion o en el folleto de inscripcion.

This notice is provided by the following company: **Anthem Blue Cross and Blue Shield**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your personal information

We may collect, use, and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in other cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career, and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Once you're a member, fnding ans wers to your questions is quick and convenient.

Just call the number on the back of your member identification (ID) card after you receive it.

Anthem

County of Henrico
General Government

HENRICO COUNTY PUBLIC SCHOOLS
HCPS

This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. If there are differences between this brochure and the Plan Document for County of Henrico Health Plan (Plan Document), the Plan Document will govern.

For more information, please call Member Services at 833-630-6742. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

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

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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