

# Choosing and using your plan

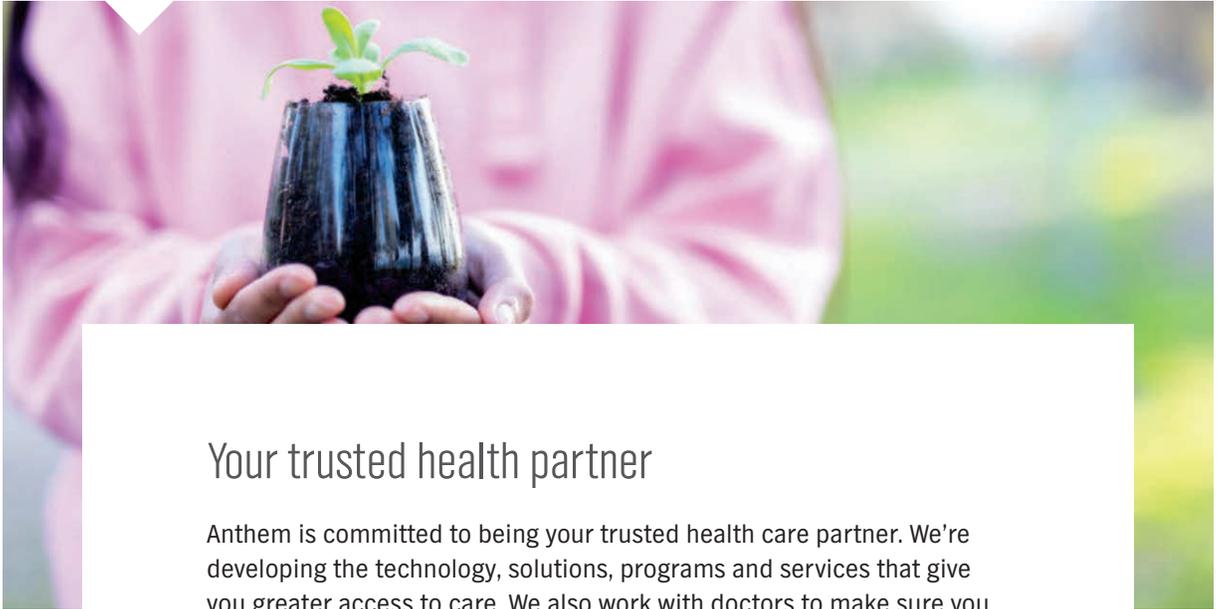
Your guide to open enrollment and  
making the most of your benefits



Rockingham County and  
Rockingham County Public Schools  
Effective October 1, 2020



## It's time to choose your plan



### Your trusted health partner

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

### Save this guide

You'll find tips on how to make the most of your benefits and save on health care costs throughout the year.





# It's time to choose your plan

## Let's get started

This is the perfect time to think about your health — where you are right now and where you want to be tomorrow. It's your opportunity to check out the benefits, programs and resources that can support your health and well-being all year long.

This guide will help you understand our plans. It's also full of tips, tools and resources that can help you reach your health and wellness goals when you become a member. So keep it handy to make the most of your benefits throughout the year.



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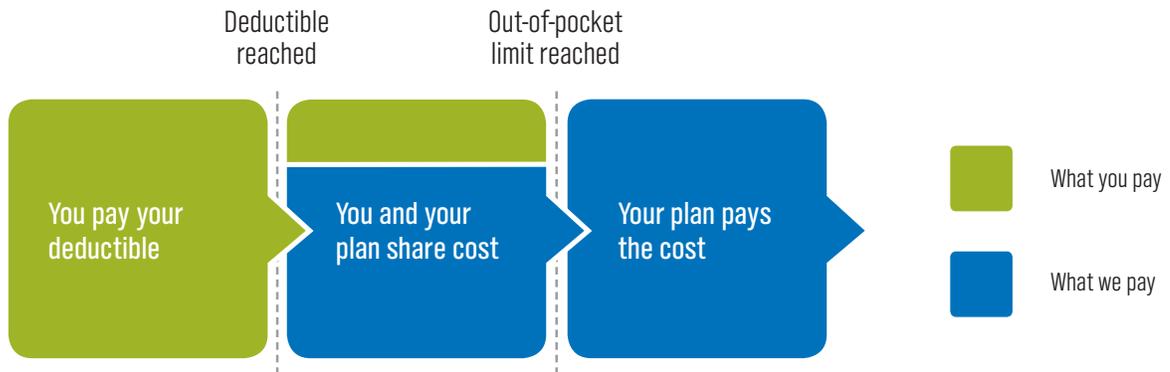


# The basics explained

Before we dive into the plan details, it may be helpful to review some health benefit basics.



## What you pay and what your plan pays



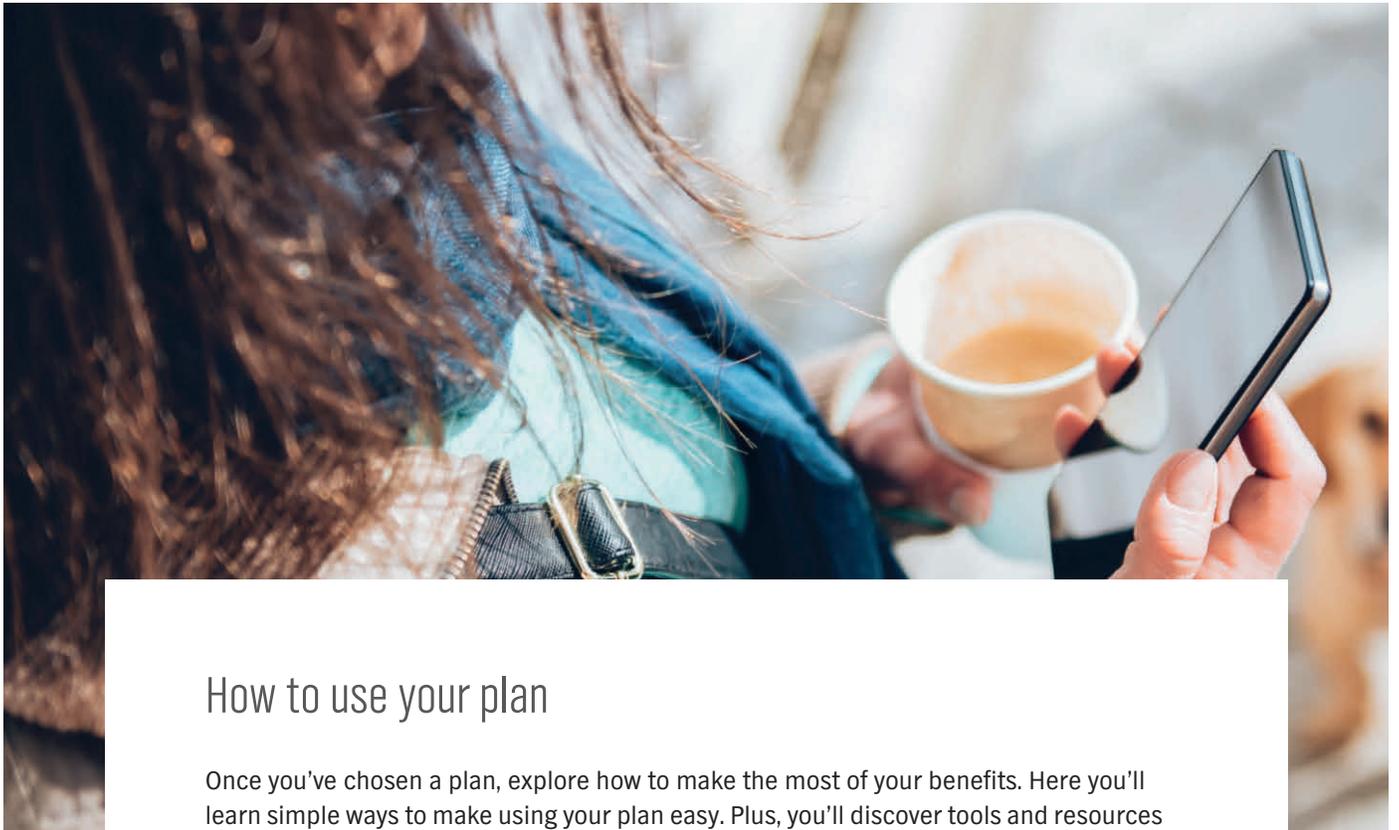
This chart is only an example. Your actual cost share will depend on your plan, the service you get and the doctor you choose. Check your plan details to see your actual share of the cost.



## Words that are helpful to know

We can help you crack the code of health insurance lingo. Here are the meanings of some common terms:

<p><b>Deductible:</b></p> <p>A set amount you pay each year for covered services before your plan starts to pay for covered health care costs.</p>	<p><b>Copay:</b></p> <p>A flat fee you pay for covered services like doctor visits.</p>	<p><b>Coinsurance:</b></p> <p>Once you've met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you'll pay.</p>
<p><b>Out-of-pocket limit:</b></p> <p>This is the most you have to pay out of your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. And some plans may still have you pay a copay at the time of service.</p>	<p><b>Premium:</b></p> <p>The premium, also called a monthly payment, is what you pay for the plan. It's the money that comes out of your paycheck. Think of it like a membership fee that's separate from what you pay when you get care.</p>	



### How to use your plan

Once you've chosen a plan, explore how to make the most of your benefits. Here you'll learn simple ways to make using your plan easy. Plus, you'll discover tools and resources that can help you reach your health and wellness goals. With Anthem, supporting your healthiest self is all part of the plan!



## How to use your plan

### Use your ID card right from your phone

Introducing the **Sydney Health** mobile app. With **Sydney Health** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor. You can even use **Sydney Health** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney Health** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney Health** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney Health** mobile app.

### Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes life so much easier. Register on the **Sydney Health** mobile app and **anthem.com** to get personalized information about your health plan and more. You can:

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- View your claims, see what's covered and what you may owe for care.
- Get support managing your health conditions and tracking your goals.
- Update your email and communication preferences.



## How to use your plan

### Find a doctor in your plan

The right doctor can make all the difference – and choosing one in your plan can save you money, too. So you'll be happy to know your plan includes lots of top-notch doctors. If you decide to get care from doctors outside the plan, it'll cost you more and your care might not be covered at all.

It's easy to find a doctor in your plan. Simply use the **Find a Doctor** tool on the **Sydney Health** mobile app or at **anthem.com** to search for doctors, hospitals, labs and other health care professionals.

You may choose to see an Enhanced Personal Health Care (EPHC) doctor as your primary care doctor. EPHC doctors spend extra time with you to provide high-quality care that is focused on your whole health, not just your symptoms. This includes building a care plan around your needs, helping you better manage any chronic disease and helping you get access to specialists when you need them.

### Schedule a checkup

Preventive care, like regular checkups and screenings, can help you avoid health problems down the road. Your plan covers these services at little or no extra cost when you see a doctor in your plan:

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

Check your plan details on the **Sydney Health** mobile app or **anthem.com** to confirm what preventive care is covered.



# How to use your plan

## Travel with peace of mind

Your health plan goes with you when you're away from home and need care immediately. The BlueCard® program gives you access to urgent care and emergency services across the country. This includes 93% of doctors and 96% of hospitals in the U.S.<sup>1</sup> If you're traveling out of the country, you can get care through the Blue Cross Blue Shield Global® Core program. It gives you access to doctors and hospitals in more than 190 countries and territories around the world.

If you're in the U.S., go to **anthem.com**. When you're outside the U.S., visit **bcbsglobalcore.com** or download the BCBS Global Core mobile app. You also can call Blue Cross Blue Shield Global Core 24/7 at 011-800-810-BLUE (2583) or call collect. To call collect, dial 0170, then tell the operator you'd like to call 011-804-673-1177.

Questions about travel benefits? Call the Member Services number on your ID card before you leave home.

## See a doctor from home

You can have a video visit with a doctor using your mobile phone, tablet or computer with a webcam, whether you're at home, at work or on the go. Doctors are available around the clock for advice, treatment and prescriptions.<sup>2</sup> Just go to **livehealthonline.com** or download the LiveHealth Online mobile app to get started.

## Where to go for care when you need it now

When it's an emergency, call 911 or head to the nearest emergency room.

But when you need nonemergency care right away:

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care – and avoid costly emergency room visits and long wait times.
- See a doctor anytime using LiveHealth Online. It works on your mobile phone, tablet or computer with a webcam.
- Call the 24/7 NurseLine and get helpful advice from a registered nurse.



<sup>1</sup> Internal data, 2019.

<sup>2</sup> Online prescribing only when appropriate based on physician judgment. LiveHealth Online is the trade name of Health Management Corporation.



# Plan extras that support your health

Learn more by registering on the **Sydney Health** app or at **anthem.com**.

Your plan comes with great tools and programs to help you reach your health goals and save money on health products and services. Plus, most of them come at no extra cost. Learn more by registering on the **Sydney Health** app or at **anthem.com**.

## Apps

Introducing the **Sydney Health** mobile app. With **Sydney Health** you can find everything you need to know about your benefits – all in one place. You'll have a custom experience that's based on your plan, your specific health care needs and lots more. And you can quickly access your digital ID card to show it to your doctor. You can even use **Sydney Health** to track your health goals, find care, compare costs, and manage your claims.

Have a question? **Sydney Health** acts like a personal health guide, answering your questions and connecting you to the right resources at the right time. And you can use the chatbot to get answers quickly. **Sydney Health** makes it easier to get things done, so you can spend more time focusing on your health. Get started by downloading the **Sydney Health** mobile app.

## Where to get care

**24/7 NurseLine** – You can connect with a registered nurse who'll answer your health questions wherever you are – anytime, day or night. They can help you

decide where to go for care and find providers in your area. All you have to do is call **1-800-337-4770**.

**Case Management** – If you're coming home after surgery or have a serious health condition, a nurse care manager can help answer your questions about your follow-up care, medicines and treatment options, coordinate benefits for home therapy or medical supplies, and find community resources to help you. Your nurse care manager will probably call you, but you also can call the Member Services number on your ID card.

**ConditionCare** – Get support from a dedicated nurse team to manage ongoing conditions like asthma, chronic obstructive pulmonary disorder (COPD), diabetes, heart disease or heart failure. Work with dietitians, health educators and pharmacists who can help you learn about your condition and manage your health.

**Future Moms** – This program can help you take care of yourself and your baby before, during and after pregnancy. You can talk to registered nurses 24/7 about your pregnancy, newborn care and more. Plus, you'll have access to dietitians and social workers, as needed.

## Want healthy advice?

Follow our **Better Care Blog** for helpful information about health benefits, living healthy and the latest member news.





## Plan extras that support your health

Learn more by registering on the [Sydney Health app](#) or at [anthem.com](#).

**LiveHealth Online** — At home, at work or on the go, you can have a video visit with a doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7 for advice, treatment and prescriptions if needed.\* The cost is usually \$59 or less, depending on your health plan. Register at [livehealthonline.com](#).

\* Online prescribing only when appropriate based on physician judgment. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

### Healthy living

**SpecialOffers** — Saving money is good. Saving money on things that are good for you — even better. With SpecialOffers, you can get discounts on products and services that help promote better health and well-being.

### Workplace perks

**Employee Assistance Program (EAP)** — If you're having a hard time and aren't sure where to turn, you can work with caring staff to help solve your problems. Your EAP is ready, whether it's a family concern, a work situation or a financial question. You can find the EAP phone number on your member ID card.

# Your summary of benefits

Rockingham County and Rockingham County Public Schools

Your Plan: Anthem KeyCare 20 750/20%/3000

Your Network: KeyCare

*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. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.*

*This benefit summary is not to be distributed without also providing access to the applicable Anthem enrollment brochure.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Overall Deductible</b> <i>See notes section to understand how your deductible works. The in and out of network deductibles are combined. Therefore, you are not required to meet separate deductibles.</i></p>		<p>\$750 person / \$1,500 family</p>
<p><b>Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum. The in and out of network out of pockets are combined. Therefore, you are not required to meet separate out of network maximums.</i></p>		<p>\$3,000 person / \$6,000 family</p>
<p><b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible.</i></p>	<p>No charge</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Doctor Home and Office Services</b></p> <p><b>Primary care visit to treat an injury or illness</b> <i>Including in office surgery</i></p>	<p>\$20 copay per visit</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Specialist care visit</b></p>	<p>\$40 copay per visit</p>	<p>40% coinsurance after deductible is met</p>

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Prenatal and Post-natal Care</b> <i>Physician global services</i>	\$20/\$40 copay then 0% coinsurance	40% coinsurance after deductible is met
<b>Other practitioner visits:</b> <b>Retail health clinic</b>  <b>On-line Medical Visit</b> <i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</i>  <b>Chiropractic services</b> <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.</i>	\$20 copay per visit  \$10 copay per visit  \$20/\$40 copay per visit	40% coinsurance after deductible is met  Not covered  40% coinsurance after deductible is met
<b>Other services in an office:</b> Allergy testing  Chemo/radiation therapy  Dialysis/Hemodialysis  Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection.</i>	Covered in full  20% coinsurance after deductible is met  20% coinsurance after deductible is met  20% coinsurance after deductible is met	40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met  40% coinsurance after deductible is met
<b>Diagnostic Services</b>  <b>Lab:</b> Office	Covered in full	40% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preferred Reference Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>X-ray:</b>		
Office	Covered in full	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b>		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Emergency and Urgent Care</b>		
<b>Emergency room facility services</b> <i>Copay waived if admitted</i>	\$250 copay per visit	Covered as In-Network

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Emergency room doctor and other services</b>	\$20/\$40 copay per visit	Covered as In-Network
<b>Ambulance Transportation</b>	20% coinsurance after deductible	Covered as In-Network
<b>Urgent Care Center Office Visit</b> Primary care visit	\$20 copay per visit	40% coinsurance after deductible is met
Specialist care visit	\$40 copay per visit	40% coinsurance after deductible is met
<b>Outpatient Mental Health and Substance Use Disorder</b> <b>Doctor Office Visit and Online Visit</b>	\$20 copay per visit	40% coinsurance after deductible is met
<b>Facility visit:</b> Facility fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Outpatient Surgery</b> <b>Facility fees:</b> Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Doctor and other services</b> Surgery	20% coinsurance after deductible is met	40% coinsurance after deductible is met

# Your summary of benefits

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

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Outpatient hospital</b>  <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Cardiac rehabilitation</b></p> <p>Office Visit</p> <p>Outpatient hospital  <i>Coverage for cardiac rehabilitation office visits/ outpatient hospital, In-Network Provider and Non-Network Provider combined is limited to 36 visits per benefit year.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Skilled nursing care (in a facility)</b>  <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 150 days per benefit year.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Hospice</b></p>	Covered in Full	40% coinsurance after deductible is met
<p><b>Durable Medical Equipment</b></p>	0% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Prosthetic Devices</b></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Not Applicable	Not Applicable
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Combined with medical out of pocket
<b>Prescription Drug Coverage</b> <i>Anthem National Drug List</i>		
<b>Tier 1 - Typically Generic</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.)</i>	\$10 copay per prescription (retail only). \$20 copay per prescription (retail maintenance and home delivery).	40% coinsurance (retail and home delivery).
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.)</i>	\$40 copay per prescription (retail only). \$80 copay per prescription (retail maintenance and home delivery).	40% coinsurance (all retail and home delivery).
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.)</i>	\$60 copay per prescription (retail only). \$120 copay per prescription (retail maintenance and home delivery).	40% coinsurance (all retail and home delivery).
<b>Tier 4 - Typically Preferred Specialty (brand and generic)</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (home delivery program.)</i>	20% coinsurance up to \$200 (retail only). 20% coinsurance up to \$400 (retail maintenance and home delivery).	40% coinsurance (all retail and home delivery).

# Your summary of benefits

## Notes:

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

### Get help in your language

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

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 682-6553.

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

(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 682-6553.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 682-6553:

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (844) 682-6553。

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 682-6553 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 682-6553.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 682-6553.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 682-6553.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 682-6553 にお電話ください。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 682-6553 로 문의하십시오.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níł hodoonih t'áadoo báąh ilinígóó. Ata' halne'ígíí la' bich'i' laadeesdzih ninizingo koj' hodiilnih (844) 682-6553.

## Language Access Services:

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (844) 682-6553.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 682-6553 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 682-6553.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 682-6553.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 682-6553.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 682-6553.

### **It's important we treat you fairly**

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



The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. **NOTE: Information about the cost of this **plan** (called the **premium**) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/aso>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (833) 630-6742 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$750</b> /member or <b>\$1,500</b> /family for <b>In-<u>Network Providers</u></b> . <b>\$750</b> /member or <b>\$1,500</b> /family for <b>Out-of-<u>Network Providers</u></b> .	Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <b>Preventive care, doctor visits, emergency room visits, hospice, lab/x-ray and for In-<u>Network Providers</u></b> . Prescription drugs.	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain preventive services without <b>cost-sharing</b> and before you meet your <b>deductible</b> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <b>plan</b>?</b>	<b>\$3,000</b> /member or <b>\$6,000</b> /family for <b>In-<u>Network Providers</u></b> . <b>\$3,000</b> /member or <b>\$6,000</b> /family for <b>Out-of-<u>Network Providers</u></b> .	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<b>Cost share</b> of routine vision care, <b>Premiums</b> , <b>Balance-Billing</b> charges, and Health Care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Will you pay less if you use a <b>network provider</b>?</b>	Yes, Key Care PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 592-9956 for a list of <b>network providers</b> .	This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware your <b>network provider</b> might use an <b>out-of-network provider</b>

		for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$20/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$40/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	40% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	40% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Tier 1 - Typically Generic	\$10 copay/ prescription for a 30 day supply \$20 copay / prescription for a 90 day supply	\$10 copay/ prescription for a 30 day supply \$20 copay / prescription for a 90 day supply	You may obtain a 30 or 90 day supply of covered prescriptions at a retail pharmacy. You may obtain a 90 day supply of covered drugs through mail order.
	Tier 2 - Typically Preferred / Brand	\$40 copay/ prescription for a 30 day supply \$80 copay / prescription for a 90 day supply	\$40 copay/ prescription for a 30 day supply \$80 copay / prescription for a 90 day supply	*See <a href="#">Prescription Drug</a> section. If you visit an Out-of- <a href="#">Network</a> pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy.
	Tier 3 - Typically Non-Preferred / <a href="#">Specialty Drugs</a>	\$60 copay/ prescription for a 30 day supply \$120 copay / prescription for a 90 day supply	\$60 copay/ prescription for a 30 day supply \$120 copay / prescription for a 90 day supply	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	20% <a href="#">coinsurance</a> up to \$200/prescription for a 30 day supply 20% <a href="#">coinsurance</a> up to \$400/prescription for a 90 day supply	20% <a href="#">coinsurance</a> up to \$200/prescription for a 30 day supply 20% <a href="#">coinsurance</a> up to \$400/prescription for a 90 day supply	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	\$20 or \$40/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Emergency room care</a>	\$250/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	<a href="#">Copay</a> waived if admitted.
If you need immediate medical attention	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Urgent care</a>	\$20 or \$40/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	-----none-----
	Facility fee (e.g, hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
	Outpatient services	Office Visit \$20/visit <a href="#">deductible</a> does not apply Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit 40% <a href="#">coinsurance</a> Other Outpatient 40% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	\$20 or \$40/visit <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Copay will apply to initial visit to confirm pregnancy. If physician submits one bill for pre-natal, delivery, and post-natal care, services are covered as Maternity Delivery Inpatient.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	100 visits/benefit period.
	<a href="#">Rehabilitation services</a>	Office Visit \$40 copay <a href="#">deductible</a> does not apply Facility Visits 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	150 days limit/benefit period combined Skilled Nursing and Inpatient Rehabilitation
	<a href="#">Habilitation services</a>	Office Visit \$40 copay <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Facility Visits	20% <a href="#">coinsurance</a>		
	Skilled nursing care	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	No charge	40% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Hospice services</a>	No charge	40% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	Covered under Blue View Vision Plan		
	Children's glasses	Covered under Blue View Vision Plan		
	Children's dental check-up	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

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

- Acupuncture
- Dental care
- Long- term care
- Bariatric surgery
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Infertility treatment
- Weight loss programs

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

- Chiropractic care 30 visits/benefit period.
- Cardiac Rehabilitation Therapy 36 visits/benefit period.
- Most coverage provided outside the United States. See [www.bcbstglobalcare.com](http://www.bcbstglobalcare.com)
- Private-duty nursing 16 hours/member/benefit period.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cio.cms.gov](http://www.cio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 27401, Richmond, VA 23279

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

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

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

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

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

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

About these Coverage Examples:



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

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

- The [plan's overall deductible](#) \$750
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,840</b>
In this example, Peg would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$150
<a href="#">Coinsurance</a>	\$2,001
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,961</b>

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

- The [plan's overall deductible](#) \$750
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$7,460</b>
In this example, Joe would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$2,225
<a href="#">Coinsurance</a>	\$25
<i>What isn't covered</i>	
Limits or exclusions	\$21
<b>The total Joe would pay is</b>	<b>\$3,021</b>

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

- The [plan's overall deductible](#) \$750
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,010</b>
In this example, Mia would pay:	
<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$750
<a href="#">Copayments</a>	\$120
<a href="#">Coinsurance</a>	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,196</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 592-9956.

**Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διεγμηνέα, τηλεφωνήστε στο (833) 592-9956.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો. (833) 592-9956.

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

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 592-9956 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 592-9956.

**Igbo (Igbo):** O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (833) 592-9956.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken importasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 592-9956.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 592-9956.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 592-9956

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 592-9956 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីស្វែងរកជាមួយអ្នកបកប្រែ សូមហៅ (833) 592-9956 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 592-9956.

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

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໃດໜຶ່ງເປັນສະເພາະ.

**Navajo (Diné):** Dii naaltsoos bika'igii lahgo bina'idilkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áa ni nizaad k'ehj' bee níl hodoonih t'áadoo bááh ilinigóó. Ata' halne'igii la' bich'i' hadeedzih nínizingo koj' hodiilnih (833) 592-9956.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 592-9956

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 592-9956 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwver selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 592-9956 aa.

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

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 592-9956.

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

## Language Access Services:

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 592-9956.

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se tofogi. Ina ia talanoa i se tagata faaliliu, vili (833) 592-9956.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 592-9956.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 592-9956.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagaragpaliwanag, tawagan ang (833) 592-9956.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 592-9956 เพื่อพูดคุยกับเรา

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**Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 592-9956 پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 592-9956.

**Yiddish (אידיש):** אויב איר האט שאלות וועגן דעם דאקומענט, האט איר ד'רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהרין פרייז. צו רעדן צו אן איבערזעצער, רופט 592-9956 (833).

**Yoruba (Yorùbá):** Tí o bá ní èyíkẹyí ibèrè nípa àkọsílẹ̀ yìí, o ní ètọ́ láti gbà ìrànwọ́ àti iwífún ní èdè rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (833) 592-9956.

## Language Access Services:

### It's important we treat you fairly

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

# Your summary of benefits

Rockingham County and Rockingham County Public Schools

Your Plan: Anthem HSA 3000/0%/3000

Your Network: KeyCare

*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. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works.</i>	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
<b>Out-of-Pocket Limit</b> <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$3,000 person / \$6,000 family	\$10,000 person / \$20,000 family
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible.</i>	No charge	20% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>  <b>Primary care visit to treat an injury or illness</b> <i>Including in office surgery</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Specialist care visit</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b> <i>Physician global services</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Other practitioner visits:</b>		

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail health clinic	0% coinsurance after deductible is met	20% coinsurance after deductible is met
On-line Medical Visit <i>Live Health Online is the preferred telehealth solutions (<a href="http://www.livehealthonline.com">www.livehealthonline.com</a>)</i>	0% coinsurance after deductible is met (current allowance is \$59)	Not covered
Chiropractic services <i>Coverage for In-Network Provider and Non-Network Provider combined is limited to 30 visits for Rehabilitation and Habilitative per benefit period.</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Other services in an office:</b>		
Allergy testing	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Chemo/radiation therapy	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Diagnostic Services</b>		
<b>Lab:</b>		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Preferred Reference Lab	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>X-ray:</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Advanced diagnostic imaging (for example, MRI/PET/CAT scans):</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Emergency and Urgent Care</b></p> <p><b>Emergency room facility services</b></p> <p><b>Emergency room doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Ambulance Transportation</b></p>	<p>0% coinsurance after deductible is met</p>	<p>Covered as In-Network</p>
<p><b>Urgent Care Center Office Visit</b></p>	<p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Outpatient Mental Health and Substance Use Disorder</b></p> <p><b>Doctor Office Visit and Online Visit</b></p> <p><b>Facility visit:</b> Facility fees</p> <p>Doctor Services</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Outpatient Surgery</b></p> <p><b>Facility fees:</b> Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and other services</b> Surgery</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Hospital Stay (all inpatient stays including maternity, mental and substance use disorder)</b></p> <p><b>Facility fees (for example, room &amp; board)</b></p> <p><b>Doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home health care</b>  <i>Coverage for In-Network and Non-Network Provider combined is limited to 100 visits per benefit period. Visit limit does not apply to Home Infusion Therapy or Home Dialysis.</i></p>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<p><b>Rehabilitation and Habilitation services (for example, physical/speech/occupational therapy):</b></p> <p><b>Office</b>  <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i></p> <p><b>Outpatient hospital</b>  <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period. Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits, and in and out of network.</i></p>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<p><b>Cardiac rehabilitation</b></p> <p>Office Visit</p> <p>Outpatient hospital  <i>Coverage for cardiac rehabilitation office visits/ outpatient hospital, In-Network Provider and Non-Network Provider combined is limited to 36 visits per benefit year.</i></p>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<p><b>Skilled nursing care (in a facility)</b>  <i>Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Provider and Non-Network Provider combined is limited to 150 days per benefit year.</i></p>	0% coinsurance after deductible is met	20% coinsurance after deductible is met

# Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Hospice</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met
<b>Prosthetic Devices</b>	0% coinsurance after deductible is met	20% coinsurance after deductible is met

# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket	Combined with medical out of pocket
<b>Prescription Drug Coverage</b> <i>Anthem National Drug List</i>		
<b>PreventiveRx Plus Drug List</b> <i>Up to 30-day supply for medications on this list (retail pharmacy)</i> <i>Up to 90-day supply for medications on this list (home delivery program)</i>	No Charge	Not Covered
<b>Tier 1 - Typically Generic</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.)</i>	0% coinsurance after deductible is met (all retail and home delivery).	20% coinsurance after deductible is met (all retail and home delivery).
<b>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generics</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.)</i>	0% coinsurance after deductible is met (all retail and home delivery).	20% coinsurance after deductible is met (all retail and home delivery).
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (retail maintenance pharmacy) Covers up to a 90 day supply (home delivery program.)</i>	0% coinsurance after deductible is met (all retail and home delivery).	20% coinsurance after deductible is met (all retail and home delivery).
<b>Tier 4 - Typically Preferred Specialty (brand and generic)</b> <i>You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Covers up to a 30 day supply (retail pharmacy). Covers up to 90 day supply (home delivery program.)</i>	0% coinsurance after deductible is met (all retail and home delivery).	20% coinsurance after deductible is met (all retail and home delivery).

# Your summary of benefits

## Notes:

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

### Get help in your language

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

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 682-6553.

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(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 682-6553.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 682-6553:

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (844) 682-6553。

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**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 682-6553.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 682-6553.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 682-6553.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 682-6553 にお電話ください。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 682-6553 로 문의하십시오.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee nił hodoonih t'áadoo báąh ilinígóó. Ata' halne'ígíí la' bich'i' hodeesdzih ninizingo koj' hodiilnih (844) 682-6553.

## Language Access Services:

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (844) 682-6553.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 682-6553 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 682-6553.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 682-6553.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 682-6553.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 682-6553.

### **It's important we treat you fairly**

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

 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <a href="#">plan</a>. The SBC shows you how you and the <a href="#">plan</a> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <a href="#">plan</a> (called the <a href="#">premium</a>) will be provided separately. This is only a summary.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, <a href="https://eoc.anthem.com/eocdps/aso">https://eoc.anthem.com/eocdps/aso</a>. For general definitions of common terms, such as <a href="#">allowed amount</a>, <a href="#">balance billing</a>, <a href="#">coinsurance</a>, <a href="#">copayment</a>, <a href="#">deductible</a>, <a href="#">provider</a>, or other <a href="#">underlined</a> terms see the Glossary. You can view the Glossary at <a href="http://www.healthcare.gov/sbc-glossary/">www.healthcare.gov/sbc-glossary/</a> or call (833) 630-6742 to request a copy.</p>		
Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,000/member or \$6,000/family for In- <a href="#">Network Providers</a> . \$6,000/member or \$12,000/family for Out-of- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> for In- <a href="#">Network Providers</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000/member or \$6,000/family for In- <a href="#">Network Providers</a> . \$10,000/member or \$20,000/family for Out-of- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Cost share of routine vision care, <a href="#">Premiums</a> , <a href="#">Balance-Billing</a> charges, and Health Care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes, KeyCare PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 592-9956 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a>

		for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> National	Tier 1 - Typically Generic	0% <a href="#">coinsurance</a> /prescription for a 30 day supply 0% <a href="#">coinsurance</a> /prescription for a 90 day supply	0% <a href="#">coinsurance</a> /prescription for a 30 day supply 0% <a href="#">coinsurance</a> /prescription for a 90 day supply	You may obtain a 30 or 90 day supply of covered prescriptions at a retail pharmacy. You may obtain a 90 day supply of covered drugs through mail order.
	Tier 2 - Typically Preferred / Brand	0% <a href="#">coinsurance</a> /prescription for a 30 day supply 0% <a href="#">coinsurance</a> /prescription for a 90 day supply	0% <a href="#">coinsurance</a> /prescription for a 30 day supply 0% <a href="#">coinsurance</a> /prescription for a 90 day supply	*See <a href="#">Prescription Drug</a> section. If you visit an Out-of- <a href="#">Network</a> pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement.
	Tier 3 - Typically Non-Preferred / <a href="#">Specialty Drugs</a>	0% <a href="#">coinsurance</a> /prescription for a 30 day supply 0% <a href="#">coinsurance</a> /prescription for a 90 day supply	0% <a href="#">coinsurance</a> /prescription for a 30 day supply 0% <a href="#">coinsurance</a> /prescription for a 90 day supply	Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy.
	Tier 4 - Typically <a href="#">Specialty</a>	0% <a href="#">coinsurance</a> /	0% <a href="#">coinsurance</a> /	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	(brand and generic)	prescription for a 30 day supply 0% <a href="#">coinsurance</a> / prescription for a 90 day supply	prescription for a 30 day supply 0% <a href="#">coinsurance</a> / prescription for a 90 day supply	
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Facility fee (e.g, hospital room)	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Outpatient services	Office Visit 0% <a href="#">coinsurance</a> Other Outpatient 0% <a href="#">coinsurance</a>	Office Visit 20% <a href="#">coinsurance</a> Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Office visits	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Home health care	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	100 visits/benefit period.
If you are pregnant	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	150 days limit/benefit period
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	combined Skilled Nursing and Inpatient Rehabilitation
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If you need help recovering or have other special health needs	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Children's eye exam	Covered under Blue View Vision Plan		
	Children's glasses	Covered under Blue View Vision Plan		
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	

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

## Excluded Services & Other Covered Services:

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

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

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

- Chiropractic care 30 visits/benefit period.
- Cardiac Rehabilitation Therapy 36 visits/benefit period.
- Most coverage provided outside the United States. See [www.bcbsglobalcare.com](http://www.bcbsglobalcare.com)
- Private-duty nursing 16 hours/benefit period.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

ATTN: [Grievances](#) and [Appeals](#), P.O. Box 27401, Richmond, VA 23279

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

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

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

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

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

About these Coverage Examples:



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

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

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

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

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

In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60

**The total Peg would pay is** **\$3,060**

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

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

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

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

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,198
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$21

**The total Joe would pay is** **\$1,219**

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

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

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

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

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,925
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0

**The total Mia would pay is** **\$1,925**

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## Language Access Services:

- German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 592-9956.
- Greek (Ελληνικά):** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διεγμηνέα, τηλεφωνήστε στο (833) 592-9956.
- Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો. (833) 592-9956.
- Haitian Creole (Kreyòl Ayisyen):** Si ou gen nespòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 592-9956.
- Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 592-9956 ।
- Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 592-9956.
- Igbo (Igbo):** O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okwowa okwu kwuo okwu, kpoo (833) 592-9956.
- Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken importasyon babaen ti lengguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 592-9956.
- Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 592-9956.
- Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. / parlare con un interprete, chiami il numero (833) 592-9956
- Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 592-9956 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីស្វែងរកជាមួយអ្នកបកប្រែ សូមហៅ (833) 592-9956 ។

**Kirundi (Kirundi):** Ugize ikibazo icyo arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 592-9956.

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

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໃດໆບໍ່ເສຍຄ່າ.  
ເພື່ອໄວ້ວັນກັບວ່າມາພາສາ, ໃຫ້ໂທຫາ (833) 592-9956.

**Navajo (Diné):** Dii naaltsoos bika'igii lahgo bina'idilkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áa ni nizaad k'ehj' bee níl hodoonih t'áadoo bááh ilinígóó.  
Ata' halné'ígíí lá' bich'í' hadeesdzih nínízingo kojí' hodiílnih (833) 592-9956.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (833) 592-9956

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (833) 592-9956 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwver selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprouch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (833) 592-9956 aa.

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

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (833) 592-9956.

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

## Language Access Services:

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (833) 592-9956.

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 592-9956.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se tofogi. Ina ia talanoa i se tagata faaliliu, vili (833) 592-9956.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (833) 592-9956.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 592-9956.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagaragpaliwanag, tawagan ang (833) 592-9956.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (833) 592-9956 เพื่อพูดคุยกับเรา

**Ukrainian (Українська):** якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (833) 592-9956.

**Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (833) 592-9956 پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 592-9956.

**Yiddish (אידיש):** אויב איר האט שאלות וועגן דעם דאקומענט, האט איר ד'רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהרין פרייז. צו רעדן צו אן איבערזעצער, רופט 592-9956 (833).

**Yoruba (Yorùbá):** Tí o bá ní èyíkẹyí ibèrè nípa àkọsílẹ̀ yìí, o ní ètọ́ láti gbà ìrànwọ́ àti iwífún ní èdè rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (833) 592-9956.

## Language Access Services:

### It's important we treat you fairly

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

# PreventiveRx<sup>SM</sup> Drug List: PreventiveRx Plus Plan (National)



PreventiveRx covers drugs that may keep you healthy because they may prevent illness and other health conditions. You can get the products on this list at low or no cost to you depending on your benefit.

This list includes only prescription products. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

Most brand-name drugs that have a generic equivalent available are not covered under this Preventive Rx benefit.

All drugs\* listed below are covered for plans with the National Drug List. If your plan has a different drug list, please check to see if these drugs are included on your drug list. PreventiveRx Plus drugs are only covered if they are included on your specific drug list.

\*Some drugs may be excluded from your benefits. Please refer to your Certificate or Evidence for Coverage for coverage limitations and exclusions.

## PreventiveRx Plus Drug List

### ASTHMA

Advair HFA  
albuterol sulfate hfa  
albuterol sulfate  
nebulization soln, syrup,  
tabs  
Arnuity Ellipta  
Breo Ellipta  
budesonide/formoterol  
aerosol  
budesonide inhalation  
suspension  
cromolyn sodium  
nebulization soln  
Dulera  
elixophyllin  
Flovent Diskus  
Flovent HFA  
fluticasone salmeterol blistr  
powder for inhalation  
levalbuterol nebulization  
soln  
metaproterenol sulfate  
syrup, tabs  
montelukast  
Perforomist  
ProAir HFA  
ProAir RespiClick  
QVAR  
Serevent Diskus  
Spiriva Respimat  
Symbicort  
terbutaline sulfate injection,  
tabs  
Theo- 24  
theochron

theophylline, ER, CR  
Ventolin HFA  
wixela inhub  
zafirlukast

### BLOOD CLOTS

Brilinta  
Coumadin  
Eliquis  
heparin  
jantoven  
warfarin  
Xarelto

### DIABETES

*Diabetic supplies including blood glucose meters, test strips and lancets require a prescription to be covered by this plan. Only blood glucose meters & blood glucose test strips by Lifescan & Roche will be covered by this benefit.*  
acarbose  
ActoPlusMet XR  
Bydureon  
Bydureon BCise  
Byetta  
chlorpropamide  
Farxiga  
glimepiride  
glipizide  
glipizide er/xl  
glipizide with metformin hcl  
glyburide  
glyburide with metformin  
hcl  
glyburide, micronized

Humalog  
Humalog KwikPen  
Humulin  
Humulin KwikPen  
Insulin Lispro  
Insulin Lispro Pen  
Janumet  
Janumet XR  
Januvia  
Jardiance  
Jentadueto  
Jentadueto XR  
Lantus  
Lantus Solostar  
Levemir  
Levemir Flexpen  
Levemir FlexTouch  
metformin hcl  
metformin hcl er (Generic  
for Glucophage XR)  
miglitol  
nateglinide  
Ozempic  
pioglitazone  
pioglitazone- glimepiride  
pioglitazone- metformin  
repaglinide  
repaglinide- metformin  
Symlin  
Synjardy  
Synjardy XR  
tolazamide  
tolbutamide  
Toujeo  
Tadjenta  
Trulicity  
Victoza

### HEART HEALTH AND HIGH BLOOD PRESSURE

acebutolol hcl  
acetazolamide  
afeditab cr  
amiloride hcl  
amiloride/ hctz  
amlodipine besylate  
amlodipine/ benazepril  
amlodipine/ olmesartan  
amlodipine/ valsartan  
amlodipine/ valsartan/ hctz  
atenolol  
atenolol/ chlorthalidone  
benazepril hcl  
benazepril hcl/ hctz  
betaxolol hcl  
Bidil  
bisoprolol fumarate  
bisoprolol fumarate/ hctz  
bumetanide  
candesartan  
candesartan/ hctz  
captopril  
captopril/ hctz  
Cartia XT  
carvedilol  
carvedilol er  
chlorothiazide  
chlorthalidone  
clonidine tabs, patches  
digitek  
digox  
digoxin  
Dilatrate SR  
diltiazem cd  
diltiazem hcl  
diltiazem hcl er

# PreventiveRx<sup>SM</sup> Drug List: PreventiveRx Plus Plan (National)



doxazosin mesylate	methyldopa/ hctz	quinapril/ hctz	fenofibrate (43, 50,	norethindrone-ethin
enalapril maleate	metolazone	ramipril	67, 130, 134, 150,	estradiol
enalapril/ hctz	metoprolol succinate	ranolazine er	200 mg capsules &	Premarin tablets
eplerenone	er	sorine	40, 48, 54, 120, 145,	Premphase
eprosartan	metoprolol tartrate	sotalol hcl	160mg tablets)	Prempro
ethacrynic acid tabs	metoprolol tart/ hctz	sotalol hcl af	fenofibric acid	raloxifene
ezetimibe	minitran	spironolactone	fluvastatin	risedronate
ezetimibe/ simvastatin	minoxidil	spironolactone/ hctz	gemfibrozil	
felodipine er	moexipril hcl	taztia xt	lovastatin	<b>STROKE</b>
fosinopril sodium	moexipril/ hctz	telmisartan	niacin ER	aspirin- dipyridamole
fosinopril/ hctz	nadolol	telmisartan/ amlodipine	pravastatin	ER
furosemide	nadolol/ bendroflumethiazide	telmisartan/ hctz	rosuvastatin	cilostazol
guanfacine hcl	nicardipine hcl	terazosin hcl	prevalite	clopidogrel bisulfate
hydralazine hcl	nifedipine	tiadyt	simvastatin	dipyridamole
hydrochlorothiazide	nifedipine er	timolol maleate tablet	Welchol 3.75 Gram	prasugrel
indapamide	nimodipine	torseamide	Oral Powder Packet	
irbesartan	nisoldipine er	trandolapril	<b>OSTEOPOROSIS</b>	
irbesartan/ hctz	Nitro-Dur 0.3, 0.8mg/ hr	trandolapril/ verapamil	alendronate sodium	
isosorbide dinitrate	nitroglycerin	triamterene/ hctz	amabelz	
isosorbide dinitrate er	nitroglycerin 400 mcg spray	valsartan	calcitonin- salmon	
isosorbide	nitroglycerin er	valsartan/ hctz	Climara	
mononitrate	nitroglycerin lingual	verapamil hcl	Climara Pro	
isosorbide	nitroglycerin sl tabs	verapamil hcl er	Combipatch	
mononitrate er	olmesartan		dotti	
isradipine	olmesartan/ hctz	<b>HIGH</b>	estradiol tab, patch	
labetalol hcl	olmesartan/ amlodipine/ hctz	<b>CHOLESTEROL</b>	estradiol/ norethindrone	
Lanoxin	perindopril	atorvastatin	acetate	
lisinopril	pindolol	atorvastatin/ amlodipine	estropipate	
lisinopril/ hctz	prazosin hcl	cholestyramine	Fosamax Plus D	
losartan	propranolol hcl	cholestyramine light	ibandronate sodium	
losartan/ hctz	propranolol hcl er	colestipol hcl	tablets	
matzim la	propranolol/ hctz	colesevelam	Jevantique	
methazolamide	quinapril hcl	ezetimibe	jinteli	
methylothiazide		ezetimibe-simvastatin	medroxyprogesterone	
methyldopa			acetate	
			Menest	

*This list may change without notice which may affect your benefit coverage. To be sure your medication is covered under the PreventiveRx benefit, call the member services number located on your ID card.*

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to [anthem.com/co/networkaccess](http://anthem.com/co/networkaccess). In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE<sup>SM</sup> Managed Care, Inc. (RIT), Healthy Alliance<sup>SM</sup> Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. 05509MUMENABS Rev. 4/1/2020

## Get help in your language

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

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

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

### Spanish

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

### Chinese

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

### Vietnamese

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

### Korean

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

### Tagalog

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

### Russian

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

### Arabic

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

### Armenian

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

### Farsi

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

### French

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

#### Japanese

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

#### Haitian

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

#### Italian

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

#### Polish

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

#### Punjabi

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

#### Navajo

Bee ná ahoót'í t'áá ni nizaad k'ehjí níká a'doowoł t'áá jík'e. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí bé'esh bee hane'í bikáá' áájí' hodiílnih. Naaltsoos bee atah nilínígíí bee né'cho'dólzingo nanitínígíí bé'esh bee hane'í bikáá' áájí' hodiílnih. (TTY/TDD: 711)

#### It's important we treat you fairly

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

# Take care of yourself

## Use your preventive care benefits

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

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

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

### Preventive vs. diagnostic care

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

### Adult preventive care

#### Preventive physical exams

##### Screening tests:

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

##### Immunizations:

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

##### Women's preventive care:

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

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

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

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

## Child preventive care

### Preventive physical exams

#### Screening tests:

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

#### Immunizations:

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

## A word about pharmacy items

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Check your medical policy for details.

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

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

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

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

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

**Welcome to your Blue View Vision plan!**

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice 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 from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at the number on the back of your ID card.

**Out-of-Network** – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. 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 BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
<b>Routine Eye Exam</b>			
A comprehensive eye examination	\$15 copay	Up to \$50 allowance	Once every 12 months
<b>Eyeglass Frames</b>			
One pair of eyeglass frames	\$140 allowance, then 20% off any remaining balance	Up to \$80 allowance	Once every 12 months
<b>Eyeglass Lenses (instead of contact lenses)</b>			
One pair of standard plastic prescription lenses:			
<ul style="list-style-type: none"> <li>• Single vision lenses</li> <li>• Bifocal lenses</li> <li>• Trifocal lenses</li> </ul>	<ul style="list-style-type: none"> <li>\$15 copay</li> <li>\$15 copay</li> <li>\$15 copay</li> </ul>	<ul style="list-style-type: none"> <li>Up to \$40 allowance</li> <li>Up to \$55 allowance</li> <li>Up to \$70 allowance</li> </ul>	Once every 12 months
<b>Eyeglass Lens Enhancements</b>			
When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.			
<ul style="list-style-type: none"> <li>• <b>Transitions</b> Lenses (for a child under age 19)</li> <li>• Standard polycarbonate (for a child under age 19)</li> <li>• Factory scratch coating</li> </ul>	<ul style="list-style-type: none"> <li>\$0 copay</li> <li>\$0 copay</li> <li>\$0 copay</li> </ul>	No allowance when obtained out-of-network	Same as covered eyeglass lenses
<b>Contact Lenses (instead of eyeglass lenses)</b>			
Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.			
<ul style="list-style-type: none"> <li>• Elective conventional (non-disposable)</li> </ul> OR	\$130 allowance, then 15% off any remaining balance	Up to \$105 allowance	Once every 12 months
<ul style="list-style-type: none"> <li>• Elective disposable</li> </ul> OR	\$130 allowance (no additional discount)	Up to \$105 allowance	
<ul style="list-style-type: none"> <li>• Non-elective (medically necessary)</li> </ul>	Covered in full	Up to \$210 allowance	
<b>Contact lens fit and follow-up</b>			
A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.			
<ul style="list-style-type: none"> <li>• Standard contact lens fitting<sup>1</sup></li> <li>• Premium contact lens fitting<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>\$0</li> <li>10% off retail price, then apply \$55 allowance</li> </ul>	<ul style="list-style-type: none"> <li>\$35 allowance</li> <li>\$35 allowance</li> </ul>	Once every 12 months

<sup>1</sup> Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement  
<sup>2</sup> Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. 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. This benefit overview is only one piece of your entire enrollment package.

**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		In-network Member Cost (after any applicable copay)	
<b>Retinal Imaging</b> - at member's option can be performed at time of eye exam		Not more than \$39	
<b>Eyeglass lens upgrades</b> When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	<ul style="list-style-type: none"> <li>• <b>Transitions</b> lenses (Adults) \$75</li> <li>• Standard Polycarbonate (Adults) \$40</li> <li>• Tint (Solid and Gradient) \$15</li> <li>• UV Coating \$15</li> <li>• Progressive Lenses<sup>1</sup> <ul style="list-style-type: none"> <li>• Standard \$65</li> <li>• Premium Tier 1 \$85</li> <li>• Premium Tier 2 \$95</li> <li>• Premium Tier 3 \$110</li> </ul> </li> <li>• Anti-Reflective Coating<sup>2</sup> <ul style="list-style-type: none"> <li>• Standard \$45</li> <li>• Premium Tier 1 \$57</li> <li>• Premium Tier 2 \$68</li> </ul> </li> <li>• Other Add-ons 20% off retail price</li> </ul>		
	<b>Additional Pairs of Eyeglasses</b> Any time from any Blue View Vision network provider.	<ul style="list-style-type: none"> <li>• Complete Pair 40% off retail price</li> <li>• Eyeglass materials purchased separately 20% off retail price</li> </ul>	
	<b>Eyewear Accessories</b>	<ul style="list-style-type: none"> <li>• Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. 20% off retail price</li> </ul>	
	<b>Conventional Contact Lenses</b>	<ul style="list-style-type: none"> <li>• Discount applies to materials only 15% off retail price</li> </ul>	

<sup>1</sup> Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

<sup>2</sup> Please ask your provider for his/her recommendation as well as the available coating brands by tier.

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



**ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM \***

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.

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

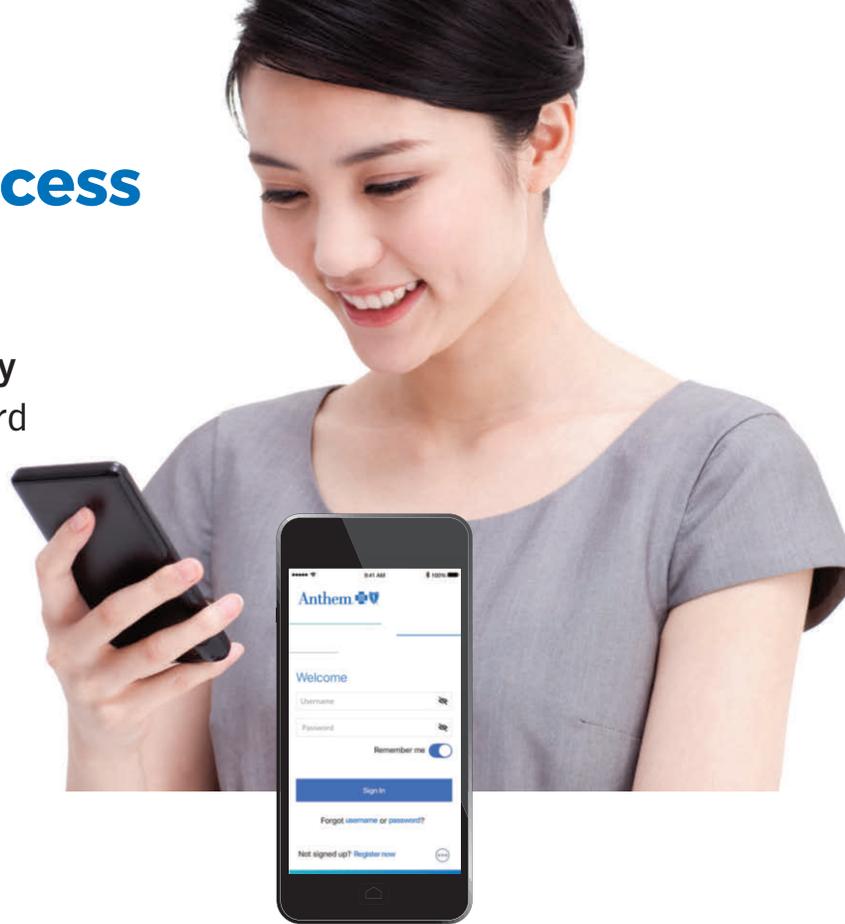
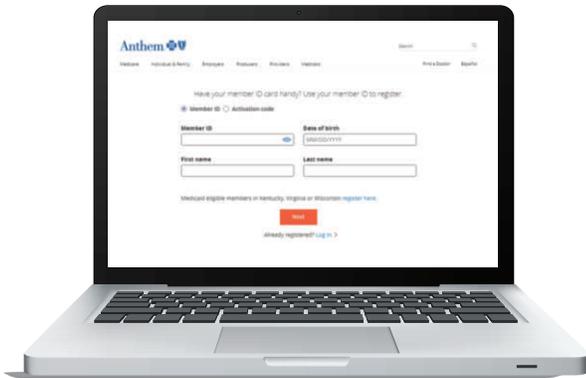
**OUT-OF-NETWORK**

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please 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 download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form.

**To 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

# You've got quick access to your health care!

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



## From your computer

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

## From your mobile device

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

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

**Need help signing up?**  
Call us at **1-833-592-9956**.



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

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

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# Looking for a doctor?

## Finding one online is fast and easy

Use our online **Find a Doctor** tool to look for doctors, hospitals, labs and other health care providers in your Anthem Blue Cross and Blue Shield plan. Check if your favorite doctor is part of your plan, or look for one near you. Avoid getting care from doctors outside of your plan if you can — it will cost you more or your plan may not cover it all.



## Here's all you need to do:

### 1 If you're a member

Go to [anthem.com](http://anthem.com), select the member icon  and log in.

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

### 1 If you're not a member yet

Go to [anthem.com](http://anthem.com).

Select **Menu**  and then choose **Find a Doctor**.

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

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

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

### 3 Select a doctor to see more information, such as:

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

### Going mobile

Use your mobile device to search for doctors, hospitals and more with our free app from the App Store® or Google Play™. Just search for Anthem Anywhere and download the app.

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



# Skip the ER

When it's not an emergency, get quick care with these options

When you need care right away and your doctor isn't available, the emergency room (ER) might be your first choice. But did you know how many ER visits are unnecessary? ERs aren't the best choice in every situation, especially when you can **save about \$1,100** by going somewhere else when it's not an emergency.<sup>1,2,3</sup> And you won't have to wait as long.

## Here's what to do when you need care fast



### Step 1: Call your primary care doctor or 24/7 NurseLine

Your doctor can help you decide where to get care, whether it's a visit to his or her office, going to the ER or somewhere else. If your doctor isn't available, you can call the **24/7 NurseLine** at the number on the back of your ID card to help you decide what to do.



### Step 2: If it's not an emergency, choose one of these options to save you time and money

Depending on your needs, you've got these choices:

- **Retail health clinic** — Usually in a major pharmacy or retail store where you can get basic health care services from a health care professional.
- **Walk-in doctor's office** — No appointment is needed for routine care and common illnesses.
- **Urgent care center** — For conditions that need care right away such as stitches, lab tests or X-rays.
- **LiveHealth Online** — Have a video visit in minutes with a board-certified doctor 24/7 on your smartphone, tablet or computer with a webcam. No appointment is needed. Just go to **livehealthonline.com** or download the free app to register and get started.

These options are more convenient than the ER. They're often open at night and on weekends, so you don't have to wait to get treated.

**If you're an HMO member**, talk to your primary care doctor to understand your options for quick care. Your doctor can also help you find quick care centers in your plan.

## When to head to the ER

If you think it's a true emergency, call 911 or go to the nearest ER.



## Where to get care quickly<sup>3</sup>

	Who usually provides care	Estimated average cost <sup>2</sup>	When to go
<b>Emergency Room</b> 	Doctors trained in emergency medicine	For non-emergencies: <b>4 hours</b> <b>\$1,404</b>	<ul style="list-style-type: none"> <li>Coughing up or vomiting blood</li> <li>Symptoms feel life-threatening or disabling</li> <li>Chest pain or severe shortness of breath</li> <li>Major injury or broken bones</li> <li>Sudden or unexplained loss of consciousness</li> </ul>
<b>Retail Health Clinic</b> 	Physician assistants or nurse practitioners	<b>30 minutes</b> <b>\$72</b>	<ul style="list-style-type: none"> <li>Allergic reactions (minor)</li> <li>Bumps, cuts, scrapes, rashes</li> <li>Burning with urination</li> <li>Burns (minor)</li> <li>Cold, cough and sore throat</li> <li>Sinus pain and fever (minor)</li> <li>Eye or ear pain or irritation</li> <li>Shots</li> </ul>
<b>Walk-in Doctor's Office</b> 	Family practice doctors	<b>30 minutes</b> <b>\$124</b>	<b>Same as retail health clinic plus...</b> <ul style="list-style-type: none"> <li>Asthma (mild)</li> <li>Back pain</li> <li>Nausea or diarrhea</li> <li>Headache (minor)</li> </ul>
<b>Urgent Care Center</b> 	Doctors who treat conditions that should be looked at right away	<b>30 minutes</b> <b>\$143</b>	<b>Same as walk-in doctor's office plus...</b> <ul style="list-style-type: none"> <li>Animal bites</li> <li>Sprains and strains</li> <li>Stitches</li> <li>X-rays</li> </ul>
<b>LiveHealth Online</b> 	Board-certified doctors	<b>10 minutes</b> <b>\$59 or less</b>	<ul style="list-style-type: none"> <li>Allergic reactions (minor)</li> <li>Headache (minor)</li> <li>Nausea or diarrhea</li> <li>Cold, cough and sore throat</li> <li>Sinus pain and fever (minor)</li> <li>Eye or ear pain or irritation</li> <li>Burning with urination</li> </ul>



### Be prepared

- Get the right care.** Whether that's finding the right doctor, specialist, therapist or something else altogether. Just use the Find a Doctor tool at [anthem.com](http://anthem.com) or call the Member Services number on your ID card and we'll guide you somewhere that's part of your plan.
- Find care near you whenever you need it.** Download the Sydney Health app to find an urgent care center, retail health clinic or walk-in doctor's office quickly and get driving directions. Just search for "Sydney Health" at the App Store® or Google Play.™



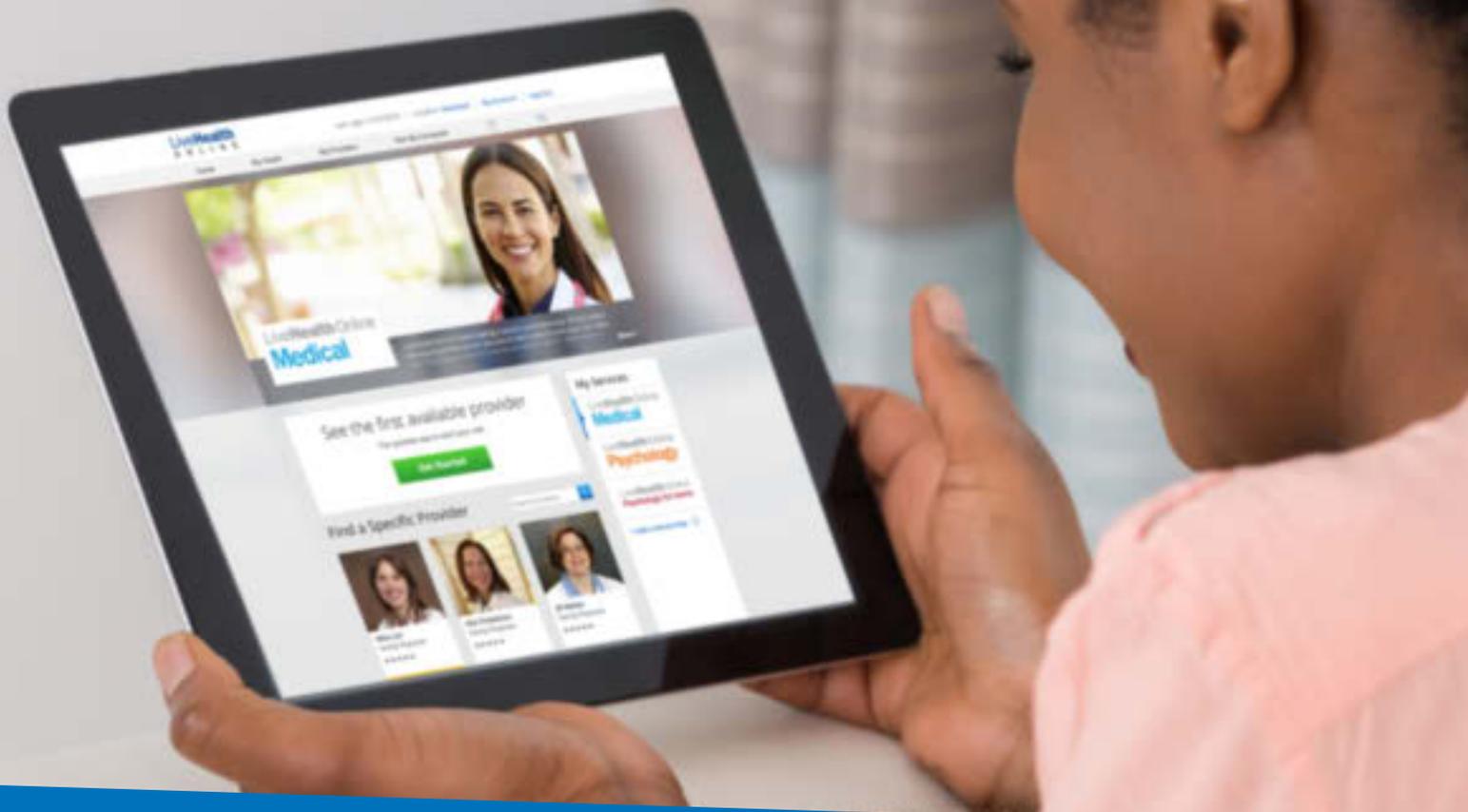
### Money-saving tip

Visit hospitals and doctors that are in your plan. If you don't, you'll often pay much more out of pocket for your care.

<sup>1</sup> If you get care from a health professional or facility that is not in your health plan, you may have much higher out-of-pocket costs.  
<sup>2</sup> National averages of the total cost, not what members paid based on Anthem members' paid claims from January 1, 2016 through December 31, 2016.  
<sup>3</sup> If you use the ER and it's not a true emergency, your claim could be denied and you may be responsible for the full cost of your ER care.

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

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



# LiveHealth Online

How to register in minutes  
before you feel sick

Using LiveHealth Online, you can have a private and secure video visit with a board-certified doctor 24/7 on your smartphone, tablet or computer with a webcam. It's a quick and easy way to get the care you need with no appointments or long wait times.

When your own doctor isn't available, use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or other common health condition. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if it's needed.<sup>1</sup>



## How to get started

Rather than waiting to sign up when you're not feeling well, register today so you're ready for a visit when you need one. To sign up, visit [livehealthonline.com](https://livehealthonline.com) or download the free LiveHealth Online app to your mobile device. Next, you:

1. Choose **Sign Up** to create your LiveHealth Online account. Then enter information like your name, email address, date of birth and create a secure password.
2. Read the *Terms of Use* and check the box to agree.
3. Choose your location in the drop-down box of states.
4. Enter your birth date and choose your gender.
5. For the question "Do you have insurance?", select **Yes**. Be sure to have your Anthem member ID card handy to complete your insurance information. If you choose **No**, you can still enter your insurance information later.
6. For **Health Plan**, in the drop-down box, select **Anthem**.
7. For **Subscriber ID**, enter your identification number, which is found on your Anthem member ID card. Select **Yes** if you are the primary subscriber or **No** if you are not the primary subscriber.
8. Insert a service key if you have one. If you don't have a service key that's OK, this is optional and not required to register.
9. Select the green **Finish** button.

## Your account securely stores your personal and health information

You can be confident knowing you can easily connect with doctors when you need to consult about certain conditions, share your health history, and schedule online visits at times that fit your schedule.

## How to use LiveHealth Online for a video visit with a doctor



## Questions about how to use LiveHealth Online?

Call toll free at **1-888-LiveHealth (548-3432)** or email [help@livehealthonline.com](mailto:help@livehealthonline.com). If you send us an email, please include your name, email address and a phone number where we can reach you.

<sup>1</sup> Prescription availability is defined by physician judgment and state regulations. Visit the home page of [livehealthonline.com](https://livehealthonline.com) to view the service map by state.

<sup>2</sup> Select a doctor licensed to practice in the state where you're physically located. If that doctor is seeing another patient, you can choose to go to an online waiting room or you can select another doctor who is available at that moment.

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

If you're a retiree or have coverage that complements your Medicare benefits, your employer sponsored health plan may not include coverage for online visits using LiveHealth Online. Check your plan documents for details. You can still use LiveHealth Online, but you may have to pay the full cost of a visit. Online visits using LiveHealth Online may not be a covered benefit for HRA and HIA+ members.

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# Choose an easier way to better health

## Health and wellness programs designed for your unique needs

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



### ConditionCare

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

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

### Future Moms

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

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

### 24/7 NurseLine

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

These nurses can:

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

## Get the support you need

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

- ConditionCare: 866-962-0957
- Future Moms: 800-828-5891
- 24/7 NurseLine: 800-337-4770

Anthem 

## What's Not Covered (Large Group PPO)

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

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

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

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

- 2) **Administrative Charges**

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

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

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

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

- 5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the “What’s Covered” section unless otherwise required by law.
- 6) **Autopsies** Autopsies and post-mortem testing unless requested by us as stated in “Physical Examinations and Autopsy” in the “General Provisions” section.
- 7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 8) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
- 9) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 10) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 11) **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).

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

- 12) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- 13) **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- 14) **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA’s Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- 15) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to:

- a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
  - b) Surgery or procedures to correct congenital abnormalities that cause Functional Impairment.
  - c) Surgery or procedures on newborn children to correct congenital abnormalities
- 16) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

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

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

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

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

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

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

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

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

- 30) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.
- 31) **Eye Exercises** Orthoptics and vision therapy.
- 32) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 33) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 34) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
- a) Cleaning and soaking the feet.
  - b) Applying skin creams to care for skin tone.
  - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- This Exclusion does not apply to the treatment of corns, calluses, and care of toenails for patients with diabetes or vascular disease.
- 35) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
- 36) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 37) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.
- If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 38) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- 39) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 40) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 41) **Home Care**
- a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
  - b) Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.
- 42) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

- 43) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- 44) **Infertility Treatment** Testing or treatment related to infertility.
- 45) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- 46) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 47) **Medical Equipment, Devices, and Supplies**
- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - c) Non-Medically Necessary enhancements to standard equipment and devices.
  - d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.
  - e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
- 48) **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to [www.medicare.gov](http://www.medicare.gov) for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
- 49) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 50) **Non-approved Drugs** Drugs not approved by the FDA.
- 51) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 52) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 53) **Off label use** Off label use, unless we must cover it by law or if we approve it.
- 54) **Personal Care, Convenience and Mobile/Wearable Devices**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
  - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
  - c) Home workout or therapy equipment, including treadmills and home gyms,
  - d) Pools, whirlpools, spas, or hydrotherapy equipment,
  - e) Hypo-allergenic pillows, mattresses, or waterbeds,
  - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

- g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- 55) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.
- 56) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.
- 57) **Routine Physicals and Immunizations:** Physical exams {and immunizations} required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
- 58) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 59) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 60) **Sterilization** Services to reverse elective sterilization.
- 61) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- 62) **Telemedicine** Non-interactive Telemedicine Services, such as audio-only telephone conversations, electronic mail message, fax transmissions or online questionnaire.
- 63) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 64) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 65) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 66) **Vision Services**
- a) Eyeglass lenses, frames, or contact lenses, unless listed as covered in this Booklet.
  - b) Safety glasses and accompanying frames.
  - c) For two pairs of glasses in lieu of bifocals.
  - d) Plano lenses (lenses that have no refractive power).
  - e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
  - f) Vision services not listed as covered in this Booklet.

- g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.
  - h) Blended lenses.
  - i) Oversize lenses.
  - j) Sunglasses and accompanying frames.
  - k) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
  - l) For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.
  - m) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
- 67) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- 68) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
- This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- 69) **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.
- 70) **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA’s Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
5. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.

7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at [www.anthem.com](http://www.anthem.com). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
9. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
10. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
11. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
12. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.  

This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
13. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
14. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy" benefit. Please see that section for details.
15. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
16. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
17. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
18. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
19. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
20. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
21. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.

22. **Non-approved Drugs** Drugs not approved by the FDA.
23. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
24. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
25. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.  
The exception to this Exclusion is described in “Covered Prescription Drugs” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.
26. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immune-compromised or diabetic.
27. **Over-the-Counter Items** Drugs, devices and products permitted to be dispensed without a prescription and available over the counter.  
This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under federal law with a Prescription.
28. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
29. **Weight Loss Drugs** Any Drug mainly used for weight loss.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment and upon renewal. If you have questions, please ask your group administrator or broker.

ABCBS-VA-LG-PPO-COC (1/20)

# We're here for you – in many languages

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

## Spanish

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

## Chinese

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

## Vietnamese

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

## Korean

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

## Tagalog

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

## Russian

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

## Armenian

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

## Farsi

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

## French

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

## Arabic

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

## Japanese

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

## Haitian

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

## Italian

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

## Polish

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

## Punjabi

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

## TTY/TTD:711

## It's important we treat you fairly

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



# The legal stuff we're required to tell you

## How we keep your information safe and secure

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

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

### How we help manage your care

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

To learn more about how we help manage your care, go to [anthem.com/memberrights](https://www.anthem.com/memberrights). To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

### Special enrollment rights

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

Get the full details

Read your **Certificate of Coverage**, which spells out all the details about your plan. You can find on [anthem.com](https://www.anthem.com).

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





## Ready to use your plan?

### Get some extra help

If you have questions, it's easy to get answers. Contact us through our online Message Center or call the Member Services number on your ID card.

