2026 open enrollment

Your guide to your health plan and benefits

Anthem Medical, Vision, Dental and EAP Plans
Prince Edward County

Anthem

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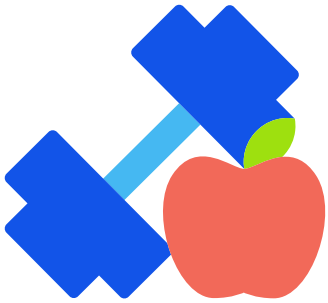
This guide is for informational purposes only. You must enroll in a plan for your benefits to start.

Welcome to Anthem

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

Why Anthem



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

The nation's largest network

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

No- or low-cost preventive care

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

Convenient virtual care

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

Health and wellness programs

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

1 Elevance Health: *2024 Notice of Annual Meeting of Shareholders and Proxy Statement* (accessed May 21, 2025): https://s202.q4cdn.com/665319960/files/doc_financials/2024/ar/2024-elevance-health-proxy-statement.pdf.
2 Blue Cross Blue Shield Association: *The Blue Cross Blue Shield System* (accessed May 21, 2025): bcbs.com.
3 In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

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Table of contents

Medical plans

Review the available plan to see how it can fit your healthcare needs

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

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

KeyCare PPO

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

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

Find care

Use our **Find Care** tool to see if your doctors are in the plan's network by visiting **anthem.com/find-care**

3 For a full list of qualified expenses, go to anthem.com/qme.

Pharmacy benefits

Reliable prescription drug coverage

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

Your plan covers:

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

Coverage requirements

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

- **Preapproval, also known as prior authorization,** helps ensure your medications are safe and appropriate. If necessary, we'll work directly with your doctor to find the best fit with no action needed on your part.
- **Step therapy:** You may need to try other medicine before we can cover the one your doctor prescribed.
- **Quantity limits:** To help protect your health, your plan may limit how much medication you can receive each month.
- **Dose optimization:** If a higher strength is available, you may be able to switch from taking multiple doses to a single dose each day.

To understand pharmacy benefits:

- Review your medication list to see if your prescriptions are covered.
- Use the Price a Medication tool on **Sydney℠ Health** to find the best price in your plan's network, which can save you more when buying certain medicines.

Maximize your prescription savings

The Price a Medication tool in the **Sydney℠ Health** app offers ways to help you lower your prescription costs, including:

- Finding the best in-network drug prices.
- Comparing the costs of generic and brand-name drugs.
- Selecting CarelonRx Pharmacy home delivery for maintenance medications.

- Check to make sure your local retail pharmacy is in your plan's network by using the Find a Pharmacy tool on **Sydney℠ Health**.
- Explore home delivery with CarelonRx Pharmacy to make getting your regular prescription medications easier and help lower your costs.
- Get more information on our specialty pharmacy once you have a health plan. Most specialty drugs are covered if you need them.

Your pharmacy options

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

The **Base Network** is our national pharmacy network with nearly 70,000 retail pharmacies across the country. To find a pharmacy, visit **anthem.com/pharmacyinformation/rxnetworks.html** and choose the Base Network list.

Dental benefits

Protect your teeth and your overall health

Dental benefits make it easier and less costly to care for your mouth — and smile. Regular dental checkups help your dentist keep your teeth and gums healthy and catch potential issues early, when they're easier to treat. Good oral health can also help improve overall health and reduce the risk of diabetes, heart disease, and other serious health conditions.[1]

Dental PPO

Your dental plan includes 100% coverage for most preventive and diagnostic services, such as regular cleanings and X-rays, if you visit a dentist in your plan's network. Most plans include two checkups each year. Your plan also includes teledentistry programs.

Your plan comes with digital resources to help you find and receive quality care, save money, and learn more about your oral health and dental benefits. These tools, along with your digital health plan ID card, are available at no extra cost on **Sydney℠ Health** and **anthem.com**.

- **Find Care:** Search for dental treatments and dentists in your plan's network and compare costs.
- **Ask a Hygienist:** Email questions and get a response within 24 to 48 hours from a team of licensed dental professionals.
- **Dental Health Assessment:** Complete questions and receive a personalized report to better understand your dental health and risk of developing tooth decay, gum disease, and oral cancer.

Dental health is important to your overall health

Did you know? Regular dental checkups aren't just good for your teeth. They can also detect health issues like diabetes, high blood pressure, and heart disease.[2]

1 National Library of Medicine: Dental Exam (May 9, 2023): medlineplus.gov.
2 The Ohio State University: *Health issues a dentist can identify by looking* (May 15, 2023): health.osu.edu.

Vision benefits

Eye care is important to your whole health

When you choose Blue View Vision, you'll be covered for routine eye exams and receive an annual allowance for eyeglasses or contact lenses. The plan features additional plan benefits to help you save even more, such as discounts on lens upgrades and extra pairs of glasses.

Save money by using an independent eye doctor, retail store, or online option that's in your plan's network. If traveling abroad, you'll have access to translation support and resources as needed.

Your vision benefits include:

- Routine adult and pediatric eye exams. A copay may apply.

If you choose eyeglasses, your plan includes:

- An annual frame allowance, savings on lens options and upgrades, and enhanced benefits at no extra cost, such as factory scratch coating.
- Discounts off the balance if you buy glasses that cost more than your benefit allowance, additional pairs of glasses, and noncovered upgrades and accessories.

If you choose contact lenses, you'll receive:

- A contact lens allowance.
- A discount off the balance if you buy conventional contact lenses that cost more than your benefit allowance.

Keep an eye on your health

Routine eye checkups go beyond making sure you're seeing clearly. They can also catch other health issues early, such as diabetes, high blood pressure, high cholesterol, and autoimmune diseases.*

* American Optometric Association: *Updated Clinical Guideline Reinforces Importance of Annual Eye Exams, Comprehensive Eye Care with Doctors of Optometry* (March 8, 2023): aoa.org.

Plan extras and workplace perks

Extra benefits that support your whole health

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

Condition support

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

24/7 NurseLine

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

ConditionCare CORE

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

Maternity

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

Building Healthy Families

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

Behavioral health

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

Behavioral Health

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

Whole health connections

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

SpecialOffers

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

Workplace extras

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

Employee Assistance Program

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

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 9GXB

Your Plan: Anthem KeyCare 300/20%/3500 with Copays Rx $10/$40/$70/20%

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	$40 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$300 person / $600 family	$600 person / $1,200 family
Overall Out-of-Pocket Limit	$3,500 person / $7,000 family	$8,750 person / $17,500 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office	No Charge	40% coinsurance after medical deductible is met
Reference Lab	No Charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$40 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.*	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Therapy Services **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Additional Services, Equipment and Devices **Durable Medical Equipment**	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. Home Delivery is optional.* **Specialty Pharmacy** *30 day supply at retail (cost shares noted below apply); up to 90 day supply at home delivery (subject to up to 3 times the 30 0day supply cost share(s) noted below). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$40 copay per prescription (retail) and $100 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$70 copay per prescription (retail) and $175 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $300 per prescription (retail and home	40% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	delivery)	

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

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

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

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

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

Anthem

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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 obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, 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

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 9GXB

Your Plan: Anthem KeyCare 500/20%/4000 with Copays Rx $10/$40/$70/20%

Your Network: KeyCare

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$500 person / $1,000 family	$1,000 person / $2,000 family
Overall Out-of-Pocket Limit	$4,000 person / $8,000 family	$10,000 person / $20,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office	No Charge	40% coinsurance after medical deductible is met
Reference Lab	No Charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.*	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Therapy Services **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Additional Services, Equipment and Devices **Durable Medical Equipment**	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. Home Delivery is optional.* **Specialty Pharmacy** *30 day supply at retail (cost shares noted below apply); up to 90 day supply at home delivery (subject to up to 3 times the 30 0day supply cost share(s) noted below). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$40 copay per prescription (retail) and $100 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$70 copay per prescription (retail) and $175 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $300 per prescription (retail and home	40% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	delivery)	

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

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

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

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

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

Anthem

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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 obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, 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

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 9GXB

Your Plan: Anthem KeyCare 1000/30%/5000 with Copays Rx $10/$40/$70/20%

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge medical deductible does not apply
Mental Health & Substance Use Disorder Services	No charge medical deductible does not apply
Specialist care	$60 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$1,000 person / $2,000 family	$2,000 person / $4,000 family
Overall Out-of-Pocket Limit	$5,000 person / $10,000 family	$12,500 person / $25,000 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Provider *virtual and office*	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postpartum care and delivery)	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Cost share is based on the setting services are received.
Diagnostic Services Lab		
Office	No Charge	50% coinsurance after medical deductible is met
Reference Lab	No Charge	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Diagnostic Services X-Ray		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Diagnostic Services Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$40 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services	30% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after medical deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.*	30% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Therapy Services **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Additional Services, Equipment and Devices **Durable Medical Equipment**	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Wigs *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. Home Delivery is optional.* **Specialty Pharmacy** *30 day supply at retail (cost shares noted below apply); up to 90 day supply at home delivery (subject to up to 3 times the 30 0day supply cost share(s) noted below). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	$10 copay per prescription (retail) and $20 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$40 copay per prescription (retail) and $100 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$70 copay per prescription (retail) and $175 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $300 per prescription (retail and home	50% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	delivery)	

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

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

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

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

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

Anthem

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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 obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, 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

Blue View Vision℠
FS.A.15.25.130.130

Anthem.
And Its Affiliate HealthKeepers, Inc.

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice 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 **1-866-723-0515**.

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
Routine Eye Exam			
A comprehensive eye examination	$15 Copay	Reimbursed Up To $30	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$130 Allowance, then 20% off any remaining balance	Reimbursed Up To $45	Once every calendar year
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses o Single vision lenses o Bifocal lenses o Trifocal lenses	 $25 Copay $25 Copay $25 Copay	 Reimbursed Up To $25 Reimbursed Up To $40 Reimbursed Up To $55	Once every calendar year
Eyeglass Lens Enhancements *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*			
o Transitions Lenses (for a child under age 19) o Standard polycarbonate (for a child under age 19) o Factory Scratch Coating	$0 Copay $0 Copay $0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* *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.*			
o Elective conventional (non-disposable) OR o Elective disposable OR o Non-elective (medically necessary)	$130 Allowance, then 15% off any remaining balance $130 Allowance *(no additional discount)* Covered in full	Reimbursed Up To $105 Reimbursed Up To $105 Reimbursed Up To $210	Once every calendar year
Contact lens fit and follow-up *A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.*			
o Standard contact lens fitting o Premium contact lens fitting	$0 Copay 10% off retail price, then apply $55 allowance	Reimbursed Up To $35 Reimbursed Up To $35	Once every calendar year

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)
Retinal Imaging – at member's option, can be performed a time of eye exam		Not more than $39

Eyeglass lens upgrades
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.
	∘ Transitions lenses (Adults)
	∘ Standard Polycarbonate (Adults)
	∘ Tint (Solid and Gradient)
	∘ UV Coating
	∘ Progressive Lenses[1]
	  ∘ Standard
	  ∘ Premium Tier 1
	  ∘ Premium Tier 2
	  ∘ Premium Tier 3
	∘ Anti-Reflective Coating[2]
	  ∘ Standard
	  ∘ Premium Tier 1
	  ∘ Premium Tier 2
	∘ Other Add-ons
		$75
		$40
		$15
		$15
		
		$65
		$85
		$95
		$110
		
		$45
		$57
		$68
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	∘ Complete Pair ∘ Eyeglass materials purchased separately	40% off retail price 20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Conventional Contact Lenses (non-disposable type)	∘ Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the available anti-reflective brands by tier.

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

Some of our in-network providers include:

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

Online stores:

GLASSES.COM glasses.com | contactsdirect contactsdirect.com | 1800contacts 1800contacts.com | LENSCRAFTERS lenscrafters.com | OPTICAL targetoptical.com | Ray-Ban ray-ban.com/insurance

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 1-866-723-0515 .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

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)**

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

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

Bassa
M̀ ɓéɖé dyí-ɓɛ̀ɖɛ̀ìn-ɖɛ̀ɔ̀ ɓɛ́ m̀ ké bɔ̃́ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɖá mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃́ɔ̃́ kɔ̃ɛ ɓɛ́ m̀ ké gbo-kpá-kpá dyé. **(TTY/TDD: 711)**

Bengali
বিনামূলেয্ এই তথয্ পাওয়ার ও আপনার ভাষায় সাহাযয্ করার অধিকার আপনার আছে। সাহাযেয্র জনয্ আপনার আইডি কাডের্ থাকা সদসয্ পরিষেবা ন□রে কল করন। **(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)**

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)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधकिार है। मदद के लएि अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (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)

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)

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)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔
(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)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (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.

WELCOME TO YOUR DENTAL PLAN!
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

Dental coverage you can count on

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE	In-Network	Out-of-Network
Annual Benefit Maximum Plan Year		
▪ Per insured person	**$1,500**	**$1,500**
D&P applies to Annual Maximum	**Yes**	**Yes**
Annual Maximum Carryover	**No**	**No**
Orthodontic Lifetime Benefit Maximum		
▪ Per eligible insured person	**$1,500**	**$1,500**
Annual Deductible (The Deductible does not apply to Orthodontic Services)		
▪ Per insured person Plan Year	**$25**	**$25**
▪ Family maximum	**3X Individual**	**3X Individual**
Deductible Waived for Diagnostic/Preventive Services	**Yes**	**Yes**
Out-of-Network Reimbursement Options:	**Prime (MAC)**	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services ▪ Periodic oral exam ▪ Teeth cleaning (prophylaxis) ▪ Bitewing X-rays: 1X per 12 months ▪ Intraoral X-rays	100% Coinsurance	100% Coinsurance	No Waiting Period
Basic Services ▪ Amalgam (silver-colored) Filling ▪ Front composite (tooth-colored) Filling ▪ Back composite Filling, Covered as Composites ▪ Simple Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Endodontics ▪ Root Canal	80% Coinsurance	80% Coinsurance	No Waiting Period
Periodontics ▪ Scaling and root planing	80% Coinsurance	80% Coinsurance	No Waiting Period
Oral Surgery ▪ Surgical Extractions	80% Coinsurance	80% Coinsurance	No Waiting Period
Major Services ▪ Crowns	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthodontics ▪ Dentures ▪ Bridges ▪ Dental implants Standard - Covered	50% Coinsurance	50% Coinsurance	No Waiting Period
Prosthetic Repairs/Adjustments	80% Coinsurance	80% Coinsurance	No Waiting Period
Orthodontic Services ·Adults & Dependent Children	50% Coinsurance	50% Coinsurance	No Waiting Periods

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.**
With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

Promoting healthy mouths for members who are pregnant or living with diabetes

If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

Finding a dentist is easy.

To select a dentist by name or location:

- Go to anthem.com/mydentalvision or the website listed on the back of your ID card.
- Call the toll-free customer service number listed on the back of your ID card.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Calendar Year

Teeth cleaning (prophylaxis) Limited to two per Calendar Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Coverage Every 3 Years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; Space Maintainers may be covered under Diagnostic and Preventive or Basic Services.

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges, tooth implants

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

Brush Biopsy Standard - Covered

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES

Orthodontia Limited to one course of treatment per member per lifetime

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage

Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions - Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed amounts
For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges $1,200 for the service and bills Anthem for that amount.
Anthem's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

Your Employee Assistance Program

Prince Edward County

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

Counseling and mental health

- Get 4 free visits for in-person or virtual counseling per person in your household, per issue each year.[2]

Work-life resources

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

Identity theft support

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

Self-improvement resources

- Log in to take self-assessments, access the Guidance to Care tool, and get a list of EAP resources specific to your needs.
- Use Emotional Well-being Resources to connect with one-on-one coaching and self-help digital tools.

Legal and financial resources

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

24/7 crisis support

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

Get the help you need, 24/7

- Visit **https://www.anthemeap.com/prince-edward-county** and log in with company name: Prince Edward County. You can also scan this QR code with your phone's camera.
- Call your EAP at **800-346-5484** for help with questions.

Anthem

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

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

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

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

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

EAP products are offered by Anthem Insurance Companies, Inc.

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The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

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

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

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

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

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

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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

Determining the primary and secondary plans

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

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

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered

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

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

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

- **Administrative Charges**

  — Charges to complete claim forms,

  — Charges to get medical records or reports,

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

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

  — Holistic medicine,

  — Homeopathic medicine,

  — Massage and massage therapy,

  — Reiki therapy,

  — Herbal, vitamin or dietary products or therapies,

  — Thermography,

  — Orthomolecular therapy,

  — Contact reflex analysis,

  — Bioenergetic synchronization technique (BEST),

  — Iridology-study of the iris,

  — Auditory integration therapy (AIT),

  — Colonic irrigation,

  — Magnetic innervation therapy,

  — Electromagnetic therapy,

- **Autopsies** Autopsies and post-mortem testing.

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

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

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

What's Not Covered

- **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at **anthem.com**.

  If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
- **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

  This Exclusion does not apply to:

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

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

  — Surgery or procedures on newborn children to correct congenital abnormalities.
- **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **Dental Treatment** Dental treatment, except as listed below.

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

  — Removing, restoring, or replacing teeth;

  — Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);

  — Services to help dental clinical outcomes.

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

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

What's Not Covered

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

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

  Please see the "Clinical Trials" section of "What's Covered" for details about coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. Please also read the "Experimental or Investigational" definition in the "Definitions" section at the end of this Booklet for the criteria used in deciding whether a service is Experimental or Investigational.
- **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.
- **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

  — Cleaning and soaking the feet.

  — Applying skin creams to care for skin tone.

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

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

What's Not Covered

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

  If your Group is not required to have Workers' Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- **Hearing Aids** For Members age 19 or older, hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids , unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- **Home Health Care**
  - — Services given by registered nurses and other health workers who are not Employees of or working under an approved arrangement with a Home Health Care Provider.
  - — Food, housing, homemaker services and home delivered meals. The exception to this Exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.
- **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.
- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.
- **Medical Equipment, Devices, and Supplies**
  - — Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
  - — Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
  - — Non-Medically Necessary enhancements to standard equipment and devices.
  - — Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.

What's Not Covered

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

- **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to **www.medicare.gov** for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
- **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- **Non-approved Drugs** Drugs not approved by the FDA.
- **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that must be covered by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- **Off label use** Off label use, unless we approve it.
- **Personal Care, Convenience and Mobile/Wearable Devices**
  - — Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
  - — First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
  - — Home workout or therapy equipment, including treadmills and home gyms,
  - — Pools, whirlpools, spas, or hydrotherapy equipment,
  - — Hypoallergenic pillows, mattresses, or waterbeds,
  - — Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
  - — Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
  - — Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - — Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

What's Not Covered

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

- **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that HealthKeepers determines require in-person contact and/or equipment that cannot be provided remotely.
- **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- **Vision Services** Vision services not described as Covered Services in this Booklet.
- **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

  This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

- **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by the Plan or the PBM.
- **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
- **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at **anthem.com**.

What's Not Covered

- **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Delivery Charges** Charges for delivery of Prescription Drugs.
- **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
- **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at **anthem.com**.
- **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
- **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by HealthKeepers.
- **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

  This Exclusion does not apply to over-the-counter drugs that must be covered under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, child, brother, sister, parent, in-law, or self.
- **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment (DME), Medical Devices and Supplies" benefit. Please see that section for details.
- **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
- **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
- **Non-approved Drugs** Drugs not approved by the FDA.

What's Not Covered

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

  The exception to this Exclusion is described in “Covered Prescription Drugs” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.
- **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

Protecting your privacy

How we keep your information safe and secure

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

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

How we help manage your care

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

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

Special enrollment rights

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

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

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

We're here for you – in many languages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾiਸਲ ਕਰਨ ਦਾ ਅਿਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਰਿਵਸ 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

Your benefits administrator or Human Resources representative will contact you with step-by-step instructions on how to enroll in your Anthem health plan.

Anthem

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

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

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

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