

Choosing and using your plan

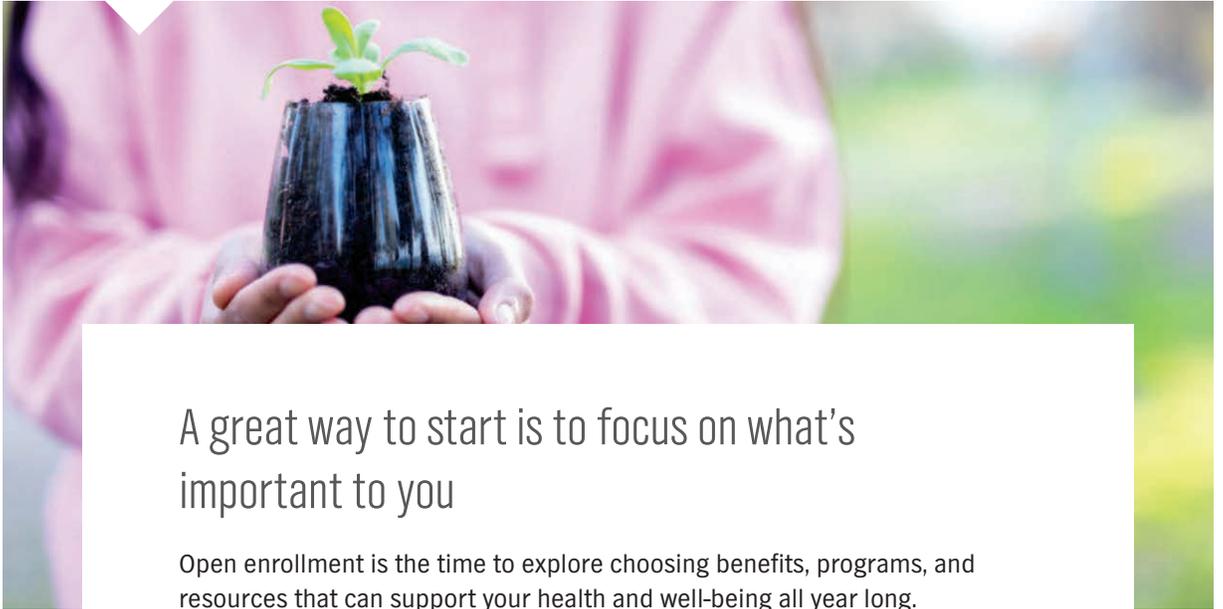
Your guide to open enrollment and
making the most of your benefits



Anthem KeyCare PPO
Accomack County
Effective June 1, 2022



It's time to choose your plan



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

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

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

Save this guide

You will find tips on how to make the most of your benefits and save on healthcare costs throughout the year.





Time to review your plan

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

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

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



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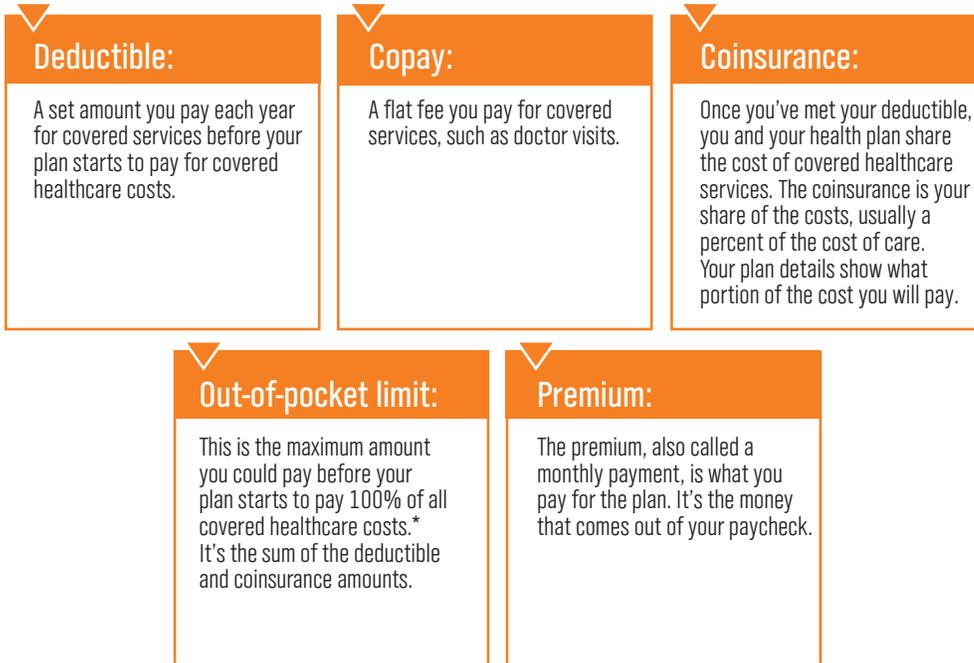
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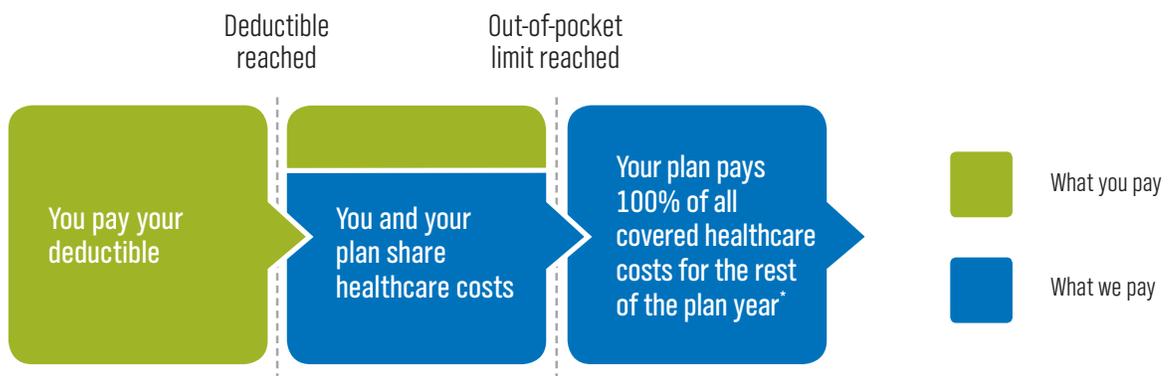
The basics of your health plan



Understanding healthcare terms



What you pay and what your plan pays



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

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



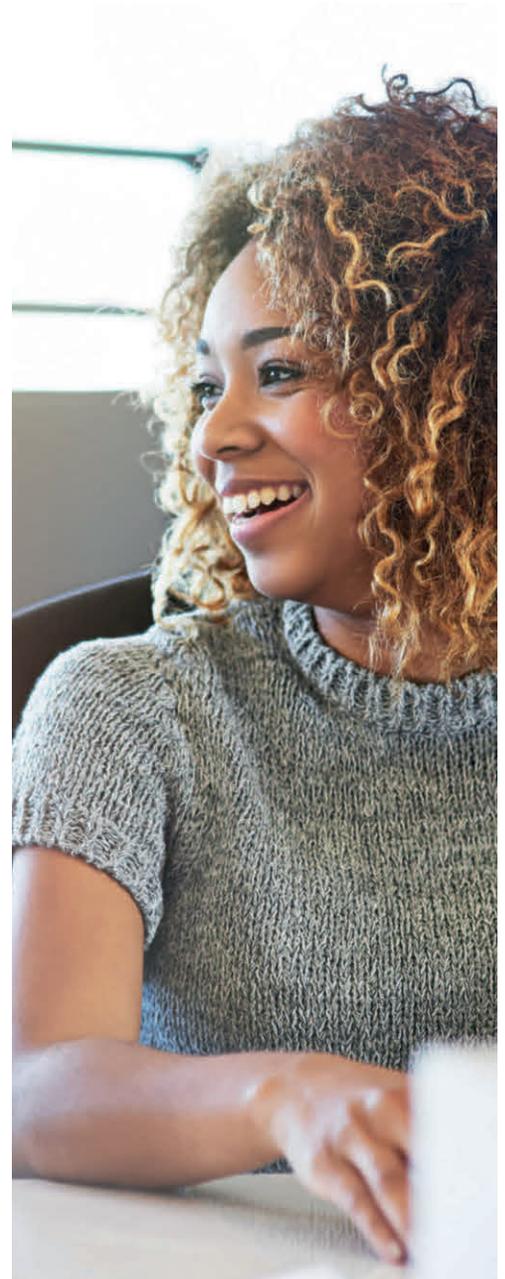
Explore your plan

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

PPO

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

- You can choose a primary care doctor from the plan's network for preventive care such as checkups and screenings.
- You do not need to have a primary care doctor to see a specialist.
- When you want to see a specialist, such as an orthopedic doctor or a cardiologist, you do not need to visit your primary care doctor first for a referral. This can save you time and a copay.
- You will pay a lower cost if you use doctors who are part of the PPO.
- You will pay a higher cost if you go to doctors who are not part of the PPO.





Vision benefits

When you choose Blue View VisionSM, you will be covered for checkups and eye exams, and receive allowances for glasses or contacts..

Blue View Vision gives you access to more than 38,000 eye doctors at more than 27,000 locations¹ across the country to make it easier to find eye care and eyewear close to home and work. Locations include retail stores such as LensCrafters®, Target Optical®, and most Pearle Vision® stores. You can order glasses and contacts online through **Glasses.com®**, **ContactsDirect®** or **1-800 CONTACTS®**.

Blue View Vision's International Travel Solution helps you when traveling outside of the U.S.:

- Find a trusted eye doctor in 20 countries and territories.²
- Receive 24/7 phone support, with translation services in 160 languages.
- If you lose or break your glasses, you can receive temporary emergency glasses with adjustable lenses delivered within 24 hours in most locations, at no additional cost.

Keep an eye on your health

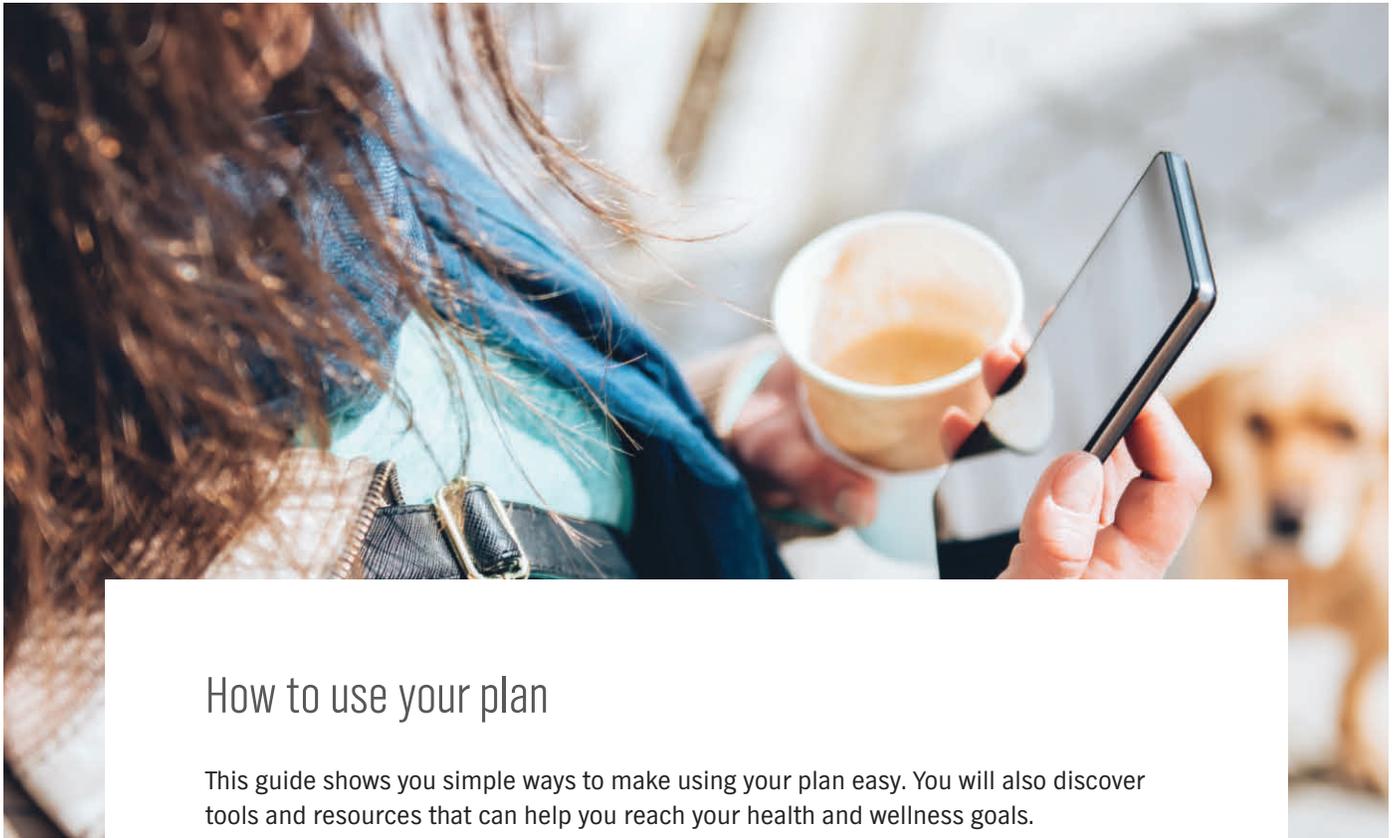
Routine eye checkups go beyond making sure you can see clearly. They also can catch other health issues early, such as diabetes, high blood pressure, high cholesterol, and rheumatoid arthritis.³



¹ NetMinder data, May 2020

² Available in Australia, Austria, Brazil, Canada, Chile, China, Colombia, Ecuador, England, France, Germany, Hong Kong SAR, Italy, Japan, Mexico, New Zealand, Peru, Puerto Rico, Spain, Switzerland, and the United States.

³ American Optometric Association website, *Evidence-Based Clinical Practice Guideline, Comprehensive Adult Eye and Vision Examination 2015* (accessed May 2021): aoa.org.



How to use your plan

This guide shows you simple ways to make using your plan easy. You will also discover tools and resources that can help you reach your health and wellness goals.



How to use your plan

Use your ID card from your phone

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

Register for online tools and resources

Accessing your health plan on your mobile phone or computer makes it more convenient to manage your plan. Register on the **Sydney Health** mobile app and **anthem.com** to receive personalized information about your health plan. You can also:

- Quickly access your digital ID card.
- Assess your symptoms at no cost, and get personalized information about a diagnosis, including over-the-counter medicine to take, and recovery time.
- Text with a board-certified doctor at no extra cost,¹ discuss treatment options, and order prescriptions.
- Find a doctor and estimate your costs before you receive care.
- View your claims, see what's covered, and what you may owe for care.
- Find support managing your health conditions and tracking your goals.
- Update your email and communication preferences.

¹ Pricing based on \$0 copay benefit eligibility offered through your plan.



How to use your plan

Find a doctor in your plan

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

To find a doctor in your plan's network, use the **Find Care** tool on the **Sydney Health** mobile app or at **anthem.com**. You can search for doctors, hospitals, and other healthcare professionals. You can also use the tool to search for high-quality, low-cost labs in your plan's network.

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

Schedule a checkup

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

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

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



How to use your plan

Access care from home in a way that works for you

- Assess your symptoms online at no cost. Answer questions through the **Sydney Health** intuitive Symptom Checker. It uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you visit a doctor.
- Text with a board-certified doctor at no extra cost.¹ **Sydney Health** can link you directly to doctors for virtual text visits. During your appointment, the doctor can evaluate your symptoms, discuss your treatment options, and order prescriptions, if you need them.
- Have a video chat with a doctor. You can also use **Sydney Health** to connect with a board-certified doctor through video visits.
- See a doctor from home. Go to **livehealthonline.com** or download the **LiveHealth Online** mobile app to begin.

Where to go for care when you need it now

When it is an emergency, call 911 or go to the nearest emergency room.

If you need nonemergency care right away:

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care to avoid costly emergency room visits and long wait times.
- See a doctor anytime using LiveHealth Online from your mobile device or computer.
- Call 24/7 NurseLine and receive helpful advice from a registered nurse.



¹ Pricing based on \$0 copay benefit eligibility offered through your plan. LiveHealth Online is the trade name of Health Management Corporation.



Plan extras that support your health

For details, register on the **Sydney Health** mobile app or at **anthem.com**.

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

Apps

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

Working with you:

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

Working for you:

- **Symptom Checker** – Answer questions through the **Sydney Health** intuitive Symptom Checker. It uses the information you provide to narrow down millions of medical data points and assess your specific symptoms before you visit a doctor.
- **Virtual text visits** – **Sydney Health** can link you directly to board-certified doctors for virtual text visits at no extra cost.* During your appointment, the doctor can evaluate your symptoms, discuss your treatment options, and order prescriptions, if you need them.
- **Virtual video visits** – You can also use **Sydney Health** to connect with a board-certified doctor through video visits.

Are you looking for healthy advice?

Follow our **Better Care Blog** ([anthem.com/blog/](https://www.anthem.com/blog/)) for helpful information about health benefits, living healthy, and the latest member news.



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



Plan extras that support your health

For details, register on the [Sydney Health mobile app](#) or at [anthem.com](#).

Mobile Health Consumer — Receive the health information you need in real time, wherever you are. Whether you want to find urgent care nearby, pull up a digital ID card, or connect with a doctor on your phone, you can in minutes. This brings together your health plan information with programs, resources, and personalized content. Start now by downloading the Mobile Health Consumer mobile app.

Anthem Skill — Our Anthem Skill for Alexa is a voice-activated assistant for your health plan. Receive answers to your healthcare questions — hands-free by enabling the Anthem Skill. It works through any Alexa-enabled device, such as an Amazon Echo, or on your mobile device using the Amazon Alexa app.

- Ask for your digital member ID card.
- Check your progress toward meeting your medical plan's deductible and out-of-pocket maximum.
- Find out how close you are to reaching your dental plan's deductible and annual maximum.

If you do not have the Amazon Alexa app, download it from Google Play™ or the App Store®.

Medical guidance

24/7 NurseLine — You can connect with a registered nurse who will answer your health questions wherever you are — anytime, day or night. They can help you decide where to go for care and find doctors and other healthcare professionals in your area. Call **800-337-4770**.

The Autism Spectrum Disorder Program — This program focuses on building a strong support system for the entire family. A specialized team of clinicians will work with you to create a customized care plan, help coordinate care, and connect you with resources in your community. Call **844-269-0538**.

Behavioral Health Resource — 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. You can call **866-785-2789**, 24/7, for help with understanding your benefits, guiding you to resources, and connecting you to the care you need.

Emotional well-being resources — Administered by Learn to Live, provides the support you need to develop resilience, reduce stress, and practice mindfulness. The online programs and personalized coaching help you work through thoughts and behaviors that affect your emotional well-being. You'll learn effective ways to manage stress, anxiety, depression, substance use, and sleep issues — at no extra cost to you. Log in to [anthem.com](#), go to My Health Dashboard, choose Programs, and select Emotional Well-being Resources to begin.

Blue Distinction® Centers — If you are having surgery or a major procedure such as knee or hip replacement, look for this designation: Blue Distinction Centers or Blue Distinction Center hospitals are recognized for excellent care and faster recovery times. Blue Distinction Centers+ are also recognized for lower costs. In addition, you do not pay extra for access to a Blue Distinction Center. It's part of your plan.

Blue Distinction® Total Care PCP — The primary care doctors (PCP) in our Blue Distinction Total Care program are different than regular doctors. They take a holistic approach to your care and take the time to make sure your overall care makes sense based on your history, specialists, medications, and lab results. They also offer you additional ways to receive care, such as by phone, email, and extended office hours.



Plan extras that support your health

For details, register on the [Sydney Health mobile app](#) or at [anthem.com](#).

Blue Precision — When it's time to choose a specialist in cardiology, obstetrics/gynecology, endocrinology, rheumatology, or pulmonary medicine, look for Anthem's Blue Precision designation. This means the doctor meets the highest professional standards for quality care and controlling costs.

Cancer Resources — The Stronger Together website is a great resource for anyone facing cancer. You will find tools and information that can help you make shared treatment decisions, prepare for care or develop a care plan, manage symptoms, and find caregiving support. Visit [cancerresources.anthem.com](#).

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

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

ConditionCare End-Stage Renal Disease — If you have end-stage renal disease (ESRD), we are here to help you with your day to day needs. A registered nurse will help you schedule dialysis care and doctor visits; follow your treatment plan; understand your medical equipment; and find helpful resources and information. You don't have to do anything extra to be part of this program. A nurse will call you to ask if you want to enroll.

ConditionCare Support — If you have lower back pain, vascular disease, or a musculoskeletal disorder, you can call a nurse care manager 24/7 for help managing your condition and following your care plan. You'll receive information that can help you avoid hospital stays and time away from work. The program is backed by a team of pharmacists, dietitians, and exercise specialists. For details, call the Member Services number on your ID card.

Future Moms — This program can help you take care of yourself and your baby before, during, and after pregnancy. You can talk to registered nurses 24/7 about your pregnancy and newborn care. You also have access to dietitians and social workers, as needed. The program includes breastfeeding support through LiveHealth Online.

Shopper program for imaging services — The cost of imaging services like X-rays, ultrasounds, MRIs, and CT scans can range from \$300 to \$3,000.* A higher price doesn't always mean better care. If your doctor lets us know you need imaging, we will shop around to find the best value. You also can call us directly at 888-953-6703. If we find an option that costs less, we will let you know. The choice of where you go is always up to you.

*Source: AIM Specialty Health®, internal claims cost analysis.

Healthy living

MyHealth Advantage — There is no cost for this service, and it can help you stay healthy and save money. You will receive reminders when you need to refill a prescription or have a checkup, test, or exam. You will also receive a personalized and confidential MyHealth Note in the mail or on the **Sydney Health** mobile app if we see something that might help you.



Plan extras that support your health

For details, register on the **Sydney Health** mobile app or at **anthem.com**.

Online Wellness Toolkit — Receive tools that help you set and achieve your unique health goals. It includes a Health Assessment, personalized trackers to monitor your progress toward reaching your goals, and fun activities that promote healthier decisions.

SpecialOffers — With SpecialOffers, you can receive discounts on products and services that help promote better health and well-being.

Staying Healthy Reminder — This yearly reminder tells you about important preventive health screenings or treatments you may need, based on your age and gender. You can receive the reminder electronically or by mail. Make your selection on **anthem.com**.

The Weight Center — This online resource connects you to information on how to manage your weight, eat healthier, and take care of your emotional well-being. It includes access to helpful tools like a body mass index (BMI) calculator, the Weight Management Playbook, and FitLife podcasts at no extra cost to you.

Workplace perks

Focus on your well-being and earn rewards up to \$200. Choose the activities you'd like to complete.

Preventive Care

Complete an annual preventive wellness exam or well woman exam with your doctor \$25

Get an annual cholesterol test¹ \$20

Complete a colorectal cancer screening (adults 45 years and older) \$25

Complete a routine mammogram (women 40 to 74) \$25

Have an annual eye exam² \$25

Get an annual flu shot \$20

Condition Management Programs

ConditionCare program: Work one-on-one with your health coach for a chronic condition and earn rewards

for participating in and completing the program³ Up to \$50 (\$20/\$30)³

Future Moms program: Moms-to-be can receive support from a registered nurse and earn rewards for completing initial, interim, and postpartum assessments⁴ Up to \$40 (\$20/\$10/\$10)⁴

Well-being Coach Telephonic — Weight Management Program: Receive one-on-one support and lifestyle coaching for weight management. Complete your goal to earn a reward.⁵ \$25

Well-being Coach Telephonic — Tobacco Cessation Program: Receive one-on-one support and lifestyle coaching for tobacco cessation. Complete your goal to earn a reward.⁶ \$25

Digital Wellness activities

Log in to your Anthem account \$5

Connect a fitness or lifestyle device \$5

Complete a health assessment and receive tailored health recommendations \$20

Complete action plans around eating healthy, weight management, physical activity, and more Up to \$25 (\$5 per action plan)

Track your steps Up to \$60 (\$2 per 50,000 steps tracked)

Complete Well-being Coach Digital daily mission check-ins⁷ Up to \$20 (\$4 per milestone)

Update your contact information \$10

When you're ready to redeem your rewards, open the **Sydney Health** app or go to **anthem.com**. Next, go to My Health Dashboard and select Redeem Rewards.

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (lipid) panel.

2 Annual eye exam reward is available if employer provides vision coverage through Anthem.

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: (Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Asthma, Diabetes, and Congestive Heart Failure (CHF). Rewards include: \$20 for program participation and \$30 for program completion.

4 Future Moms assessments completion dates: Initial assessment must be completed by day 97; Interim assessment must be completed by 1 day prior to delivery; Postpartum Assessment must be completed by 56 days after delivery. Rewards include: \$20 for an initial assessment; \$10 for an interim assessment; and \$10 for a postpartum assessment.

5 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a BMI of 30 or higher.

6 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.

7 Members may earn rewards for completing quarterly Well-being Coach digital milestones while logging daily mission check-in activities on the digital coaching app. Daily mission check-ins reward values: first check-in: \$4; next 15 check-ins during first quarter: \$4; 25 check-ins during second through fourth quarters: \$4 each quarter. The digital coaching app download is available using Sydney Health or anthem.com. Well-being Coach Digital is provided by Lark Health.

Any rewards earned must be redeemed before the end of the current plan year. Unused rewards are forfeited, and your reward balance will reset to zero at the beginning of the new plan year.

All preventive care activities are claims-based. Medical waivers apply to all claim-based activities.

Rewards eligibility applies to only employees and their spouse/domestic partner. Members must be active on the plan and activity must take place during the plan effective year. It may take a little time once you complete a wellness activity before you see the reward amount in your account.



Plan extras that support your health

For details, register on the **Sydney Health** mobile app or at **anthem.com**.

A subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim. Anthem claims are required for claims-based activity rewards. Anthem claims are required for claims-based activity rewards and may take up to 60 days to adjudicate. Product availability may vary. The reward amount redeemed may be considered income to you and/or your spouse/domestic partner and subject to state and federal taxes in the tax year it is paid. You and/or your spouse/domestic partner should consult a tax expert with any questions regarding tax obligations. The list of retailers available for electronic gift card rewards redemption is subject to change. Log on to anthem.com or open the Sydney Health app to explore the electronic gift card options available to you.

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

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code:

Your Plan: Anthem KeyCare Plus 15/20%/3500 Rx \$15/\$50/\$85/20%

Base Rx Network with R90; Optional Home Delivery

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person / \$0 family	\$1,000 person / \$2,000 family
Out-of-Pocket Limit	\$3,500 person / \$7,000 family	\$8,750 person / \$17,500 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p>	<p>Preferred PCP \$10 copay per visit</p> <p>PCP \$15 copay per visit</p> <p>\$15 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

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

VA/LG/Anthem KeyCare Plus 15/20%/3500 Rx \$15/\$50/\$85/20%/6F2W/01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$35 copay per visit	30% coinsurance after medical deductible is met
Medical Chats and Virtual Visits for Primary Care from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device	No charge	
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device Primary Care (PCP) and Mental Health and Substance Abuse Specialist Care	\$5 copay per visit	\$35 copay per visit
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	<u>Preferred PCP</u> \$10 copay per visit <u>PCP</u> \$15 copay per visit \$35 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	\$300 copay per pregnancy \$15 copay per visit \$15 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Other Services in an Office</u> Allergy Testing	\$10 copay per visit	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy	20% coinsurance	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance	30% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance	30% coinsurance after medical deductible is met
Surgery	\$35 copay per surgery	30% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab Office Preferred Reference Lab Outpatient Hospital	No charge No charge \$35 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
X-Ray Office Outpatient Hospital	20% coinsurance \$35 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office	20% coinsurance	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	\$200 copay per visit	30% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance	\$35 copay per visit \$300 copay per visit 20% coinsurance 20% coinsurance	30% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse</u> Doctor Office Visit Facility Visit Facility Fees Doctor Services	\$15 copay per visit \$150 copay per visit \$15 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Freestanding Surgical Center Doctor and Other Services Hospital	\$300 copay per visit \$150 copay per visit \$35 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>\$300 copay per day to a maximum of \$1,500 per admission</p> <p>\$35 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p>
<p>Rehabilitation services <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$15 copay per visit</p> <p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$35 copay per visit</p> <p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i></p>	<p>\$300 copay per day to a maximum of \$1,500 per admission</p>	<p>30% coinsurance after medical deductible is met</p>
<p>Inpatient Hospice</p>	<p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance	30% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance	30% coinsurance after medical deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage <i>Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.</i>		
Home Delivery Pharmacy <i>Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i>		
Tier 1 - Typically Generic <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$15 copay per prescription, deductible does not apply (retail) and \$38 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$50 copay per prescription, deductible does not apply (retail) and \$125 copay per prescription, deductible does not apply (home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</i>	\$85 copay per prescription, deductible does not apply (retail)	30% coinsurance, deductible does not apply (retail) and Not

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	and \$213 copay per prescription, deductible does not apply (home delivery)	covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance up to \$300 per prescription, deductible does not apply (retail and home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>		
<u>Children's Vision (up to age 19)</u>		
Child Vision Deductible	\$0 person	\$0 person
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
<u>Adult Vision (age 19 and older)</u>		
Adult Vision Deductible	\$0 person	\$0 person
Vision exam <i>Limited to 1 exam per benefit period.</i>	\$15 copay	Reimbursed Up to \$30

Notes:

- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
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Language Access Services:

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

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It's important we treat you fairly

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

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code:

Your Plan: Anthem KeyCare Plus 20/20%/4000 Rx \$15/\$50/\$85/20%

Base Rx Network with R90; Optional Home Delivery

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person / \$0 family	\$1,000 person / \$2,000 family
Out-of-Pocket Limit	\$4,000 person / \$8,000 family	\$10,000 person / \$20,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	30% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after medical deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p>	<p>Preferred PCP \$10 copay per visit</p> <p>PCP \$20 copay per visit</p> <p>\$20 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>

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VA/LG/Anthem KeyCare Plus 20/20%/4000 Rx \$15/\$50/\$85/20%/6F2Y/01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$40 copay per visit	30% coinsurance after medical deductible is met
Medical Chats and Virtual Visits for Primary Care from our Online Provider K Health, its affiliated Provider groups, via our mobile app, website or Anthem-enabled device	No charge	
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device Primary Care (PCP) and Mental Health and Substance Abuse Specialist Care	\$5 copay per visit	\$40 copay per visit
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	<u>Preferred PCP</u> \$10 copay per visit <u>PCP</u> \$20 copay per visit \$40 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 30 visits per benefit period.</i>	\$300 copay per pregnancy \$20 copay per visit \$20 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Other Services in an Office</u> Allergy Testing	\$10 copay per visit	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy	20% coinsurance	30% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance	30% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance	30% coinsurance after medical deductible is met
Surgery	\$40 copay per surgery	30% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab Office Preferred Reference Lab Outpatient Hospital	No charge No charge \$40 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
X-Ray Office Outpatient Hospital	20% coinsurance \$40 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office	20% coinsurance	30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	\$300 copay per visit	30% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance	\$40 copay per visit \$300 copay per visit 20% coinsurance 20% coinsurance	30% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse</u> Doctor Office Visit Facility Visit Facility Fees Doctor Services	\$20 copay per visit \$150 copay per visit \$20 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Freestanding Surgical Center Doctor and Other Services Hospital	\$300 copay per visit \$150 copay per visit \$40 copay per visit	30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met 30% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>\$300 copay per day to a maximum of \$1,500 per admission</p> <p>\$40 copay per visit</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p>
<p>Rehabilitation services <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 30 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$20 copay per visit</p> <p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$40 copay per visit</p> <p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p> <p>30% coinsurance after medical deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i></p>	<p>\$300 copay per day to a maximum of \$1,500 per admission</p>	<p>30% coinsurance after medical deductible is met</p>
<p>Inpatient Hospice</p>	<p>20% coinsurance</p>	<p>30% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance	30% coinsurance after medical deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance	30% coinsurance after medical deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage <i>Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.</i>		
Home Delivery Pharmacy <i>Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i>		
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	and \$213 copay per prescription, deductible does not apply (home delivery)	covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) <i>Per 30 day supply (specialty pharmacy).</i>	20% coinsurance up to \$300 per prescription, deductible does not apply (retail and home delivery)	30% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

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

Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo koj̄' hodiilnih (833) 592-9956.

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

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

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

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

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

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

It's important we treat you fairly

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

Your Summary of Benefits Accomack County - High Plan Anthem Blue Cross and Blue Shield Dental Complete

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 employee benefits booklet.

Dental coverage you can count on

Your Anthem Blue Cross and Blue Shield (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 – (Calendar Year) <ul style="list-style-type: none"> Per insured person Diagnostic & Preventive Services are applied to the Annual Benefit Maximum Annual Maximum Carryover	\$1,500 No	\$1,500 No
Orthodontic Lifetime Benefit Maximum <ul style="list-style-type: none"> Per eligible insured person 	\$1,000	\$1,000
Annual Deductible – (Calendar Year) <ul style="list-style-type: none"> Per insured person Family maximum 	\$50 3x single member deductible	\$50 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	80th percentile	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services <ul style="list-style-type: none"> Periodic oral exam Teeth cleaning (prophylaxis) Bitewing X-rays (<18, once in 12 mos.; 18+, once in 24 mos.) Periapical X-rays 	100% coinsurance	80% coinsurance	No waiting period
Basic Services <ul style="list-style-type: none"> Amalgam (silver-colored) filling Front composite (tooth colored) filling Back composite (tooth colored) filling, alternated to amalgam allowance Simple extractions 	80% coinsurance	80% coinsurance	No waiting period
Endodontics <ul style="list-style-type: none"> Root canal 	80% coinsurance	80% coinsurance	No waiting period
Periodontics <ul style="list-style-type: none"> Scaling and root planing 	80% coinsurance	80% coinsurance	No waiting period
Oral Surgery <ul style="list-style-type: none"> Surgical extractions 	80% coinsurance	80% coinsurance	No waiting period
Major Services <ul style="list-style-type: none"> Crowns 	50% coinsurance	50% coinsurance	No waiting period
Prosthodontics <ul style="list-style-type: none"> Dentures Bridges Dental implants (not covered) 	50% coinsurance	50% coinsurance	No waiting period
Prosthetic Repairs/Adjustments	50% coinsurance	50% coinsurance	No waiting period
Orthodontic Services <ul style="list-style-type: none"> Adults and dependent children* 	50% coinsurance	50% coinsurance	No waiting period

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 employee benefits booklet. **In the event of a discrepancy between the information in this summary and the employee benefits booklet, the booklet will prevail.**

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 an independent company offering dental-management services to Anthem. To learn more about the program, please visit the International Emergency Dental Web site at www.decare.com/internationalDentalProgram.do.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

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

TO CONTACT US:

Call	Write	Email
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.	Go to anthem.com or the website listed on the back of your ID card.

Limitations & Exclusions	
<p>Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your employee benefits booklet for a full list.</p> <p><u>Diagnostic and Preventive Services</u></p> <p>Oral evaluations (exam) – Limited to two per Calendar Year</p> <p>Teeth cleaning (prophylaxis) – Limited to two per Calendar Year</p> <p>Periapical X-rays, single film – Limited to four films per 12-month period</p> <p>Complete series X-rays (panoramic or full-mouth) Limited to once every 60 months</p> <p>Topical fluoride application – Limited to once every 12 months for members through age 18</p> <p>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.</p> <p><u>Basic and/or Major Services**</u></p> <p>Fillings – Limited to once per surface per tooth in any 24 months</p> <p>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.</p> <p>Crowns – Limited to once per tooth in a seven-year period</p> <p>Fixed or removable prosthodontics – dentures, partials, bridges 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.</p> <p>Root canal therapy – Limited to once per lifetime per tooth; coverage is for permanent teeth only.</p> <p>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</p> <p>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</p> <p>Brush biopsy – (Not covered)</p>	<p>**Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.</p> <p>ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES – if Orthodontia is included as a benefit of your dental plan Orthodontia – Limited to one course of treatment per member per lifetime</p> <p>Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your employee benefits booklet for a full list.</p> <p>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</p> <p>Orthodontics (unless included as part of your dental plan benefits) – Orthodontic braces, appliances and all related services</p> <p>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</p> <p>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.</p> <p>Extractions – Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member</p>

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.

This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company, whichever is applicable.

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

Anthem develops an out-of-network dental fee schedule/rate to determine the maximum allowed amount for services provided by an out-of-network dentist. This schedule may be changed or updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data.

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.

Say Ted's dental plan allows him 50% coinsurance for either in- or out-of-network services... Ted chooses to get a crown from an out-of-network dentist who charges \$1,200 for the service and bills Anthem for that amount. If Anthem's maximum allowed cost for this dental service is \$800, this means there will be a \$400 difference. The out-of-network dentist can “balance bill” Ted for that amount.

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

- Dentist's charge: \$1,200
- Anthem's maximum allowed cost: \$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 Summary of Benefits
Accomack County - Low Plan
Anthem Blue Cross and Blue Shield Dental Complete**

WELCOME TO YOUR DENTAL PLAN!

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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 – (Calendar Year) <ul style="list-style-type: none"> Per insured person Diagnostic & Preventive Services are applied to the Annual Benefit Maximum 	\$1,000	\$1,000
Annual Maximum Carryover	No	No
Orthodontic Lifetime Benefit Maximum <ul style="list-style-type: none"> Per eligible insured person 	Not applicable	Not applicable
Annual Deductible – (Calendar Year) <ul style="list-style-type: none"> Per insured person Family maximum 	\$50 3x single member deductible	\$50 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	80th percentile	

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Diagnostic and Preventive Services <ul style="list-style-type: none"> Periodic oral exam Teeth cleaning (prophylaxis) Bitewing X-rays (<18, once in 12 mos.; 18+, once in 24 mos.) Periapical X-rays 	100% coinsurance	80% coinsurance	No waiting period
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Endodontics <ul style="list-style-type: none"> Root canal 	80% coinsurance	80% coinsurance	No waiting period
Periodontics <ul style="list-style-type: none"> Scaling and root planing 	80% coinsurance	80% coinsurance	No waiting period
Oral Surgery <ul style="list-style-type: none"> Surgical extractions 	80% coinsurance	80% coinsurance	No waiting period
Major Services <ul style="list-style-type: none"> Crowns 	Not covered	Not covered	Not applicable
Prosthodontics <ul style="list-style-type: none"> Dentures Bridges Dental implants (not covered) 	Not covered	Not covered	Not applicable
Prosthetic Repairs/Adjustments	Not covered	Not covered	Not applicable
Orthodontic Services <ul style="list-style-type: none"> Not covered 	Not covered	Not covered	Not applicable

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Limitations & Exclusions	
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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
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 <ul style="list-style-type: none"> • Single vision lenses • Bifocal lenses • 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 <i>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</i>			
<ul style="list-style-type: none"> •  Lenses (for a child under age 19) • Standard polycarbonate (for a child under age 19) • 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) <i>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.</i>			
<ul style="list-style-type: none"> • Elective conventional (non-disposable) OR • Elective disposable OR • 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

This is a primary vision plan with benefits intended to cover only corrective eyewear. 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)
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.	<ul style="list-style-type: none"> • Transitions lenses (Adults) • Standard Polycarbonate (Adults) • Tint (Solid and Gradient) • UV Coating • Progressive Lenses¹ <ul style="list-style-type: none"> • Standard \$65 • Premium Tier 1 \$85 • Premium Tier 2 \$95 • Premium Tier 3 \$110 • Anti-Reflective Coating² <ul style="list-style-type: none"> • Standard \$45 • Premium Tier 1 \$57 • Premium Tier 2 \$68 • Other Add-ons 20% off retail price 	
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	<ul style="list-style-type: none"> • Complete Pair 40% off retail price • Eyeglass materials purchased separately 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)	<ul style="list-style-type: none"> • Discount applies to materials only 	15% off retail price

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

²Please 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:



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 በመታወቁዎ 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

Mì bédé dyí-bédèin-déò b'é m' kè b'ò nià kε kè gbo-kpá- kpá dyé dé m' bídí-wùdùün bó pídyi. Éá mébà jè gbo-gmò Kpòè nòbà nià ni Dyí-dyoìn-b'èò k'òε b'é m' kè gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডের থাকা সদস্য পরিষেবা নম্বরে কল করুন। (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 अधिकार है। मदद के लिए 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 nomba 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 کے حصول 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 yí kí o sì sèrànwo ní èdè rẹ̀ lófẹ́. Pe Nọmbà àwọn ìpèsè ọmọ-ẹgbẹ́ lóri káàdì ìdánimọ́ rẹ̀ fún ìrànwo. (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>.

Employee Assistance Program Service Summary Accomack County



Available 24/7, 365 days a year
Everything you share is confidential.*

When you need help meeting life's challenges, the Anthem Blue Cross and Blue Shield Employee Assistance Program (EAP) is here for you and your household members. Check out some of the services we offer — at no cost to you:



Counseling

- Up to 4 visits per issue
- Face-to-face counseling or online visits via LiveHealth Online
- Can call EAP or use the online Member Center to initiate services



myStrength

- Online “health club for your mind”
- E-learning modules and mood trackers
- Library of videos, articles and inspirational quotes
- Supports development of personal action plans



Legal consultation

- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Online resources, including free legal forms, seminars and a library of articles



Dependent care and daily living resources

- Information available on child care, adoption, summer camps, college placement, elder care and assisted living through the EAP website
- Phone consultation with a work-life specialist
- For help with everyday needs, like pet sitting, relocation resources and more



Financial consultation

- Phone meeting with financial professionals
- Consultation available during regular business hours — no time limits or appointments needed
- Online resources, including articles, calculators and budgeting tools



Other anthemEAP.com resources

- Well-being articles, podcasts and monthly webinars
- Self-assessment tools for depression, anxiety, relationships, alcohol use, eating habits and more



ID recovery

- Identity theft risk level checked by specialists
- Help with reporting to consumer credit agencies
- Assistance filling out paperwork and negotiating with creditors



Crisis consultation

- Toll-free number for emergencies
- Round-the-clock help available

Need help? Give EAP a try today.

Call us at 800-346-5484. Or go to anthemEAP.com
and enter your company code: Accomack County.

* In accordance with federal and state law, and professional ethical standards.
This document is for general informational purposes. Check with your employer for specific information about benefits, limitations and exclusions.

Language Access Services – (TTY/TDD: 711)

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.
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。

Anthem Blue Cross and Blue Shield complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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



GOOD HEALTH IS WORTH IT

Focus on your well-being and earn rewards up to \$200

The more activities you complete, the greater your reward.

Your whole health matters, and we want to reward you for taking care of it. The Wellbeing Solutions program, sponsored by your employer, connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of \$200 in rewards. Don't wait, use your SydneySM Health app or visit anthem.com to learn more.

Activity type	Activities	Amount
 Preventive care measures How you earn: Receive your reward when claims are processed	Complete a colorectal cancer screening (45 years and older)	\$25
	Complete a routine mammogram (women 40 to 74)	\$25
	Complete an annual preventive wellness exam or well woman exam with your doctor	\$25
	Get an annual cholesterol test ¹	\$20
	Get an annual flu shot	\$20
	Have an annual eye exam ²	\$25
 Condition management programs How you earn: Reach certain benchmarks or complete a program	ConditionCare program: Work one-on-one with your health coach for a chronic condition and earn rewards for participating in and completing the program ⁴	Up to \$50 (\$20 participation/\$30 completion)
	Future Moms program: Moms-to-be can receive support from a registered nurse and earn rewards for completing initial, interim, and postpartum assessments ⁵	Up to \$40 (\$20 initial/\$10 interim/\$10 postpartum assessments)
	Wellbeing Coach Telephonic – Weight Management Program: Receive one-on-one support and lifestyle coaching for weight management. Complete your goal to earn a reward ⁶	\$25
	Wellbeing Coach Telephonic – Tobacco Cessation Program: Receive one-on-one support and lifestyle coaching for tobacco cessation. Complete your goal to earn a reward ⁶	\$25
 Digital Wellness activities How you earn: Complete activities in the Sydney Health SM app or on anthem.com	Complete action plans around eating healthy, weight management, physical activity, and more	Up to \$25 (\$5 per action plan)
	Complete a health assessment and receive tailored health recommendations	\$20
	Complete Well-being Coach Digital daily mission check-ins ⁶	Up to \$20 (\$4 per milestone)
	Connect a fitness or lifestyle device	\$5
	Log in to your Anthem account	\$5
	Track your steps	Up to \$60 (\$2 per 50,000 steps tracked)
Update your contact information	\$10	



Well-being Coach can help you meet your goals

Well-being Coach offers multiple options to help you meet your health goals. Our digital coaching app offers personalized 24/7 support on the go. Well-being Coach combines smart technology and proven behavioral therapy techniques to help you maintain a healthy weight, quit tobacco, and improve your nutrition, activity, mindfulness and sleep. Well-being Coach is powered by Lark and accessible from the Sydney Health app.

If you prefer a helping hand and would like additional support meeting your health goals for high-risk weight management and tobacco cessation, Well-being Coach gives you access to a certified health coach by phone. You and your health coach will identify healthy habits and develop custom action plans to achieve your health goals. No matter how you connect, you can earn rewards with Well-being Coach.

How to redeem your rewards

When you're ready to redeem your rewards, open the **Sydney Health app** or go to **anthem.com**. Then go to *My Health Dashboard*, select **Redeem Rewards**, and use your rewards credit toward an electronic gift card.

You choose from popular retailers including MasterCard, Amazon, Bed Bath & Beyond, Gap (all brands), Staples, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.

Open the **Sydney Health app** or log into **anthem.com** anytime to explore the electronic gift card options available to you.

If you'd like more information about any of the Wellbeing Solutions activities, call the Member Services number on the back of your ID card or contact Member Services through the Sydney Health app

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (Lipid) panel

2 Routine Annual eye exam reward is available if employer provides vision coverage through Anthem.

3 Future Moms assessments completion dates: Initial assessment must be completed by day 97; Interim assessment must be completed by 1 day prior to delivery; Postpartum Assessment must be completed by 56 days after delivery.

4 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a BMI of 30 or higher.

5 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.

6 Members may earn rewards for completing quarterly Well-being Coach Digital milestones while logging daily mission check-in activities on the digital coaching app: daily Mission check-ins: 1st check-in: \$4, next 15 check-ins during 1st quarter: \$4, 25 check-ins for quarters 2-4: \$4 each quarter) The digital coaching app download is available using Sydney Health or anthem.com.

Well-being Coach Digital is provided by Lark Health.

All preventive care activities are claims-based. Medical waivers apply to all claim-based activities.

Rewards eligibility applies to only employees and their spouse/domestic partner. Members must be active on the plan and activity must take place during the plan effective year. It may take a little time once you complete a wellness activity before you see the reward amount in your account.

Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim. Anthem claims are required for claims-based activity rewards and may take up to 60 days to adjudicate.

Product availability may vary.

The reward amount redeemed may be considered income to you and/or your spouse/domestic partner and subject to state and federal taxes in the tax year it is paid. You and/or your spouse/domestic partner should consult a tax expert with any question regarding tax obligations.

The list of retailers available for electronic gift card rewards redemption is subject to change. Open the Sydney Health app or log on to anthem.com or to explore the electronic gift card options available to you.

Sydney HealthSM is offered through an arrangement with CareMarket, Inc. ©2020-2021.

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Engagement Package 200 MEM 09/21



A program focused on helping you improve your health

Introducing digital diabetes prevention coaching

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

This program can help you:



Lose
weight



Eat
healthier



Increase
activity



Sleep
better



Manage
stress

Better health is within your reach

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



Weight loss with Lark

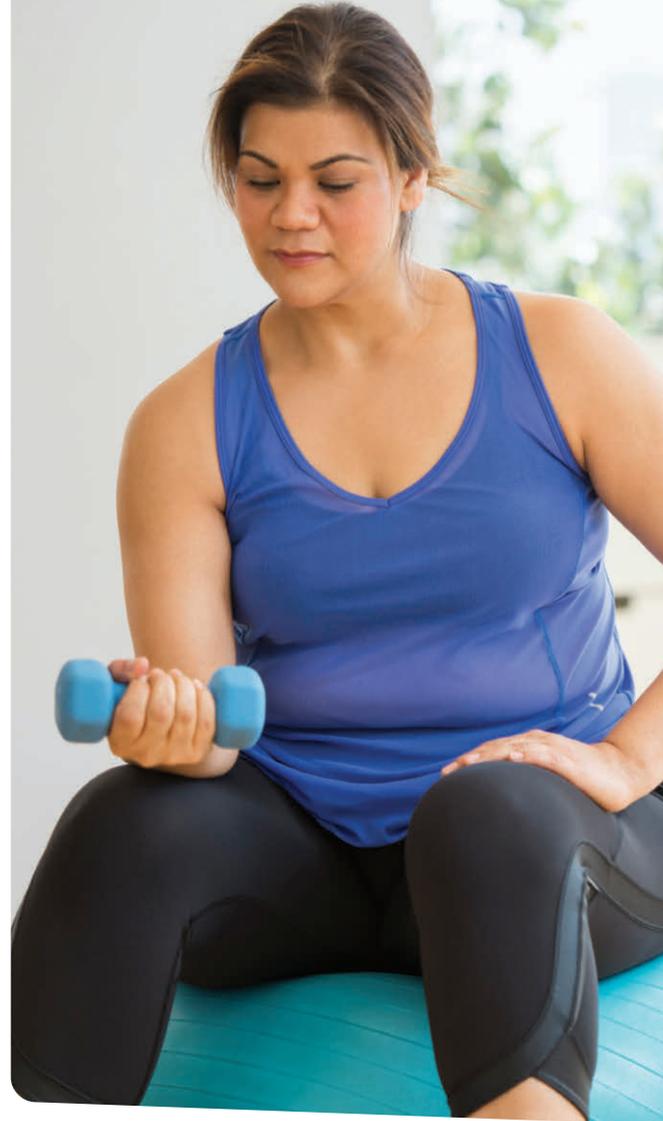
Losing weight can make a big difference in lowering your risk for type 2 diabetes. Lark members lose an average of 4.2% of their body weight in 12 months on the diabetes prevention program.² As part of the program, you receive a wireless scale at no extra cost to help you track your weight loss progress.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

24/7 coaching support

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

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

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



Learn if you are at risk for prediabetes

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



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

² Lark internal data

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

IDENTITY REPAIR, CREDIT AND IDENTITY MONITORING SERVICES FROM ANTHEM

Worried about identity theft? Rest easy, we've got you covered. Anthem has partnered with AllClear ID, a leading identity protection service, to help keep your personal information secure. This service is offered with our health plans **at no extra cost**.

Here's what you get:

AllClear Identity Repair

This benefit is available to all of our health plan members automatically — no enrollment required. If you ever become a victim of identity theft or are concerned there's a problem with your credit, AllClear will help you fix the issues and restore your information. **Just call AllClear ID at 1-855-227-9830**. They'll assign an investigator to be your guide and advocate, who will be there from start until finish.

AllClear Credit and Identity Theft Monitoring

Sign up for this extra layer of protection at no extra charge. This offering helps you know what's going on with your credit activity. In addition to credit and identity theft monitoring, you'll get:

- Identity repair.
- An identity theft insurance policy (up to \$1 million).
- ChildScan for minors (databases are scanned to detect unauthorized use of a child's Social Security number).
- An annual credit score and credit report (on request).
- The ability to set, renew and remove 90-day fraud alerts on your credit file to help protect them from fraud.

How do I get started?

To get all the great benefits of AllClear's credit and identity theft monitoring, just go to **anthemcares.allclearid.com** and submit your name and email address. Next, you'll get an email with a redemption code and instructions on how to create an online account. You'll provide your name, contact information, Social Security number and the redemption code. You can also sign up by calling 1-855-227-9830, Monday to Saturday, from 8 a.m. to 8 p.m. Central.

Once you're enrolled, you'll get alerts when banks and creditors open new accounts in your name. You'll also be alerted if any of your personal information is reported by security professionals — including the Federal Bureau of Investigation (FBI). This includes your Social Security number, credit card numbers, bank account logins and more.

At any time, if something doesn't seem right, you can contact AllClear ID for help.

Extra security and more

To learn more about AllClear ID's identity theft insurance policy and the other protection services, or to add family members to your plan, visit **anthemcares.allclearid.com**.

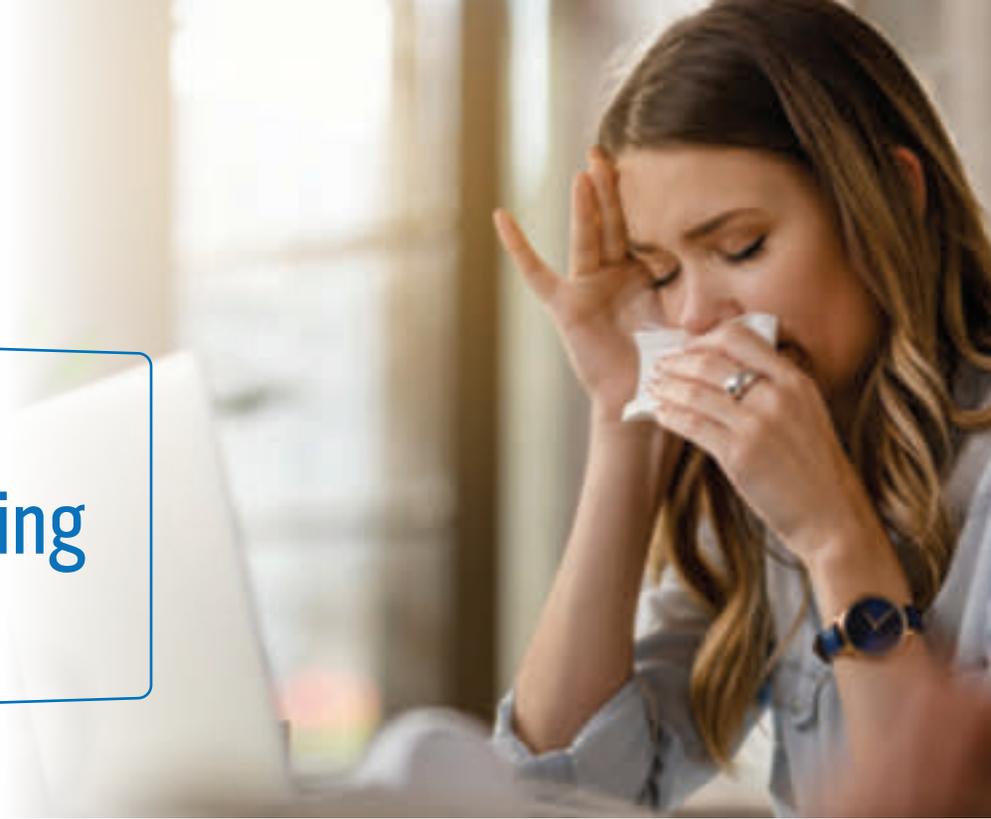
On the All Clear ID website, you'll find an FAQ that will answer many of your questions and give you more details on each service. And you can rest easy knowing AllClear ID will never share your private information with third parties.



Want to know more?

Go to **anthemcares.allclearid.com** or call AllClear ID directly at **1-855-227-9830**, Monday to Saturday, from 8 a.m. to 8 p.m. Central.

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Connect with virtual support using Sydney Health

Now you can connect more easily to the care you need through the Sydney Health mobile app. Have a live video visit with a board-certified doctor on your mobile device or computer with a camera.

Visit with a doctor for common health concerns

Doctors are available 24/7 with no appointments or long wait times. During an online video visit, doctors can assess your condition, give medical advice, and send prescriptions to the pharmacy of your choice, if needed.¹

What people say about online visits²



96%

Said the person they saw (provider) was professional and helpful



96%

Felt provider understood their concerns



94%

Were able to book a virtual visit sooner than an in-person visit

A doctor can help with these conditions through a video visit:

- ✓ Coronavirus
- ✓ Flu
- ✓ Cold and fever
- ✓ Minor rashes
- ✓ Sore throat
- ✓ Headaches

Download the Sydney Health app or sign up at [anthem.com](https://www.anthem.com) today to connect with a doctor online when you need care.



¹ Prescription availability is defined by physician judgment.
² Based on Sydney Health utilization trends from top national clients.

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Expanding your virtual care options

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

Visit with a doctor at your convenience

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

- ① **Chat with a doctor 24/7 without an appointment**
 - Urgent care support for health issues, such as allergies, a cold, or the flu.
 - New prescriptions for concerns such as a cough or a sinus infection.
- ② **Schedule a virtual primary care appointment**
 - Routine care, including wellness check-ins and prescription refills.
 - Personalized care plans for chronic conditions, such as asthma or diabetes.

Assess your symptoms with the Symptom Checker

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

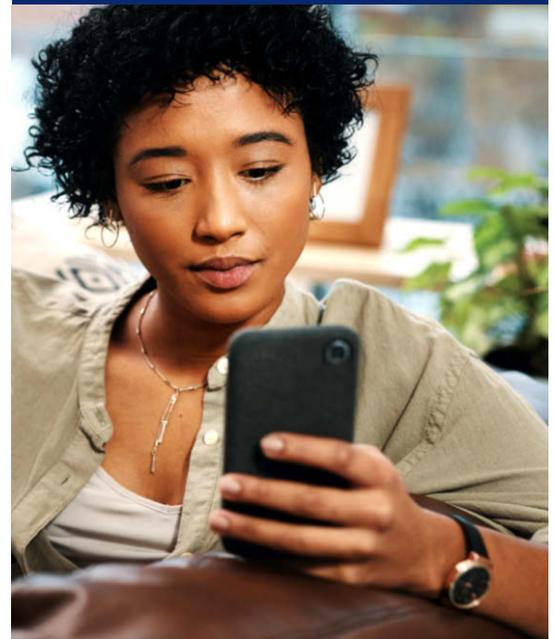
Save money and time with virtual care

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

▶ Download our Sydney Health mobile app today.



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



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

*K Health analysis of Q4 2020 visit dispositions.

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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

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.



The ins and outs of coverage

(continued)

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: <ul style="list-style-type: none"> Keeps its status as an employer. Stays in our service area. Meets our guidelines for employee participation and premium contribution. Pays the required health care premiums. Doesn't commit fraud or misrepresent itself.
	●		Your employer: <ul style="list-style-type: none"> Makes a bad payment. Voluntarily cancels coverage (30-days advance written notice required). Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan. Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	●		<ul style="list-style-type: none"> We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice). We decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		●	You and your employer received a 30-day advance written notice that the coverage was being changed (services were added to your plan or the copays were lowered). Copays can be increased or services can be decreased only when it is time for your group to renew its coverage.

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

Renewed	Canceled	When you
●		<ul style="list-style-type: none"> Stay eligible for your employer's coverage. Pay your share of the monthly payment (premium) for coverage. Don't commit fraud or misrepresent yourself.
	●	Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.
	●	<ul style="list-style-type: none"> Lose your eligibility for coverage. Don't make required payments or make bad payments. Commit fraud. Are guilty of gross misbehavior. Don't cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries). Let others use your ID card. Use another member's ID card. File false claims with us. Your coverage will be canceled after you receive a written notice from us.



The ins and outs of coverage

(continued)

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.



The ins and outs of coverage

(continued)

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 <i>not</i> 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	●	



The ins and outs of coverage

(continued)

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered (PPO)

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

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

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

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

- 2) **Administrative Charges**

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

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

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

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

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

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

This Exclusion does not apply to:

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

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

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

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

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

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

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

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

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

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

- 43) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- 44) **Infertility Treatment** Testing or treatment related to infertility.
- 45) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- 46) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
- 47) **Medical Equipment, Devices, and Supplies**
- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
 - d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.
 - e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
- 48) **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions." If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
- 49) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 50) **Non-approved Drugs** Drugs not approved by the FDA.
- 51) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- 52) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 53) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, *nutritional formulas and dietary supplements that you can buy over the counter* and those you can get without a written Prescription or from a licensed pharmacist.
- 54) **Off label use** Off label use, unless we must cover it by law or if we approve it.
- 55) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet]

EPO Only:

- 56) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care, or Authorized Services.
- 57) **Personal Care, Convenience and Mobile/Wearable Devices**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

- c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment,
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
 - g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- 58) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Care Services” benefit.
- 59) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. This exclusion does not apply to wigs needed after cancer treatment.
- 60) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.
- 61) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care” benefit.

Optional EPO/Non-HPN:

- 62) **Services Received Outside of Virginia** Services received from a Provider outside of Virginia. This does not apply to:
- a) Emergency or Urgent Care; or
 - b) Covered Services approved in advance by HealthKeepers.
- 63) **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.
- 64) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 65) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 66) **Sterilization** Services to reverse elective sterilization.
- 67) **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).

- 68) **Telemedicine** Non-interactive Telemedicine Services, such as audio-only telephone conversations, electronic mail message, fax transmissions or online questionnaire.
- 69) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 70) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 71) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 72) **Vision Services**
- a) Eyeglass lenses, frames, or contact lenses, unless listed as covered in this Booklet.
 - b) Safety glasses and accompanying frames.
 - c) For two pairs of glasses in lieu of bifocals.
 - d) Plano lenses (lenses that have no refractive power).
 - e) Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
 - f) Vision services not listed as covered in this Booklet.
 - g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Booklet.
 - h) Blended lenses.
 - i) Oversize lenses.
 - j) Sunglasses and accompanying frames.
 - k) For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
 - l) For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.
 - m) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
- 73) **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.
- 74) **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.
- 75) **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.
- 76) **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

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

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

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

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

15. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
16. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
17. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
18. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment and Medical Devices” benefit. Please see that section for details.
19. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
20. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
21. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
22. **Non-approved Drugs** Drugs not approved by the FDA.
23. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
24. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, *nutritional formulas and dietary supplements that you can buy over the counter* and those you can get without a written Prescription or from a licensed pharmacist.
25. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
The exception to this Exclusion is described in “Covered Prescription Drugs” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.
26. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
27. **Over-the-Counter Items** Drugs, devices and products permitted to be dispensed without a prescription and available over the counter.
This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care” benefit under federal law with a Prescription.
28. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
29. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
30. **Weight Loss Drugs** Any Drug mainly used for weight loss.



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

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Protecting your privacy

How we keep your information safe and secure

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

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

How we help manage your care

To see if your health benefits will cover a treatment, procedure, hospital stay, or medicine, we use a process called utilization management (UM). Our UM team is made up of doctors and pharmacists who want to be sure you 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](https://www.anthem.com/memberrights). To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special enrollment rights

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

- **If you had another health plan that was canceled.** If you, your dependents, or your spouse are no longer eligible for benefits with another health plan (or if the employer stops contributing to that health plan), you may be able to enroll with us. You must enroll within 31 days after the other health plan ends (or after the employer stops paying for the plan). For example: You and your family are enrolled through your spouse's health plan at work. Your spouse's employer stops paying for health coverage. In this case, you and your

spouse, as well as other dependents, may be able to enroll in one of our plans.

- **If you have a new dependent.** You gain new dependents from a life event, such as marriage, birth, adoption, or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you marry, your new spouse and any new children may be able to enroll in a plan.
- **If your eligibility for Medicaid or SCHIP changes.** You have a special period of 60 days to enroll after:
 - You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible..
 - You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

For full details, read your plan documents, which contain everything you need to know about your plan. You can find them on [anthem.com](https://www.anthem.com).

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 plan is here for you to use

If you would like extra help

If you have questions, we are here to help. Contact us through our online Message Center or call the Member Services number on your ID card.



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