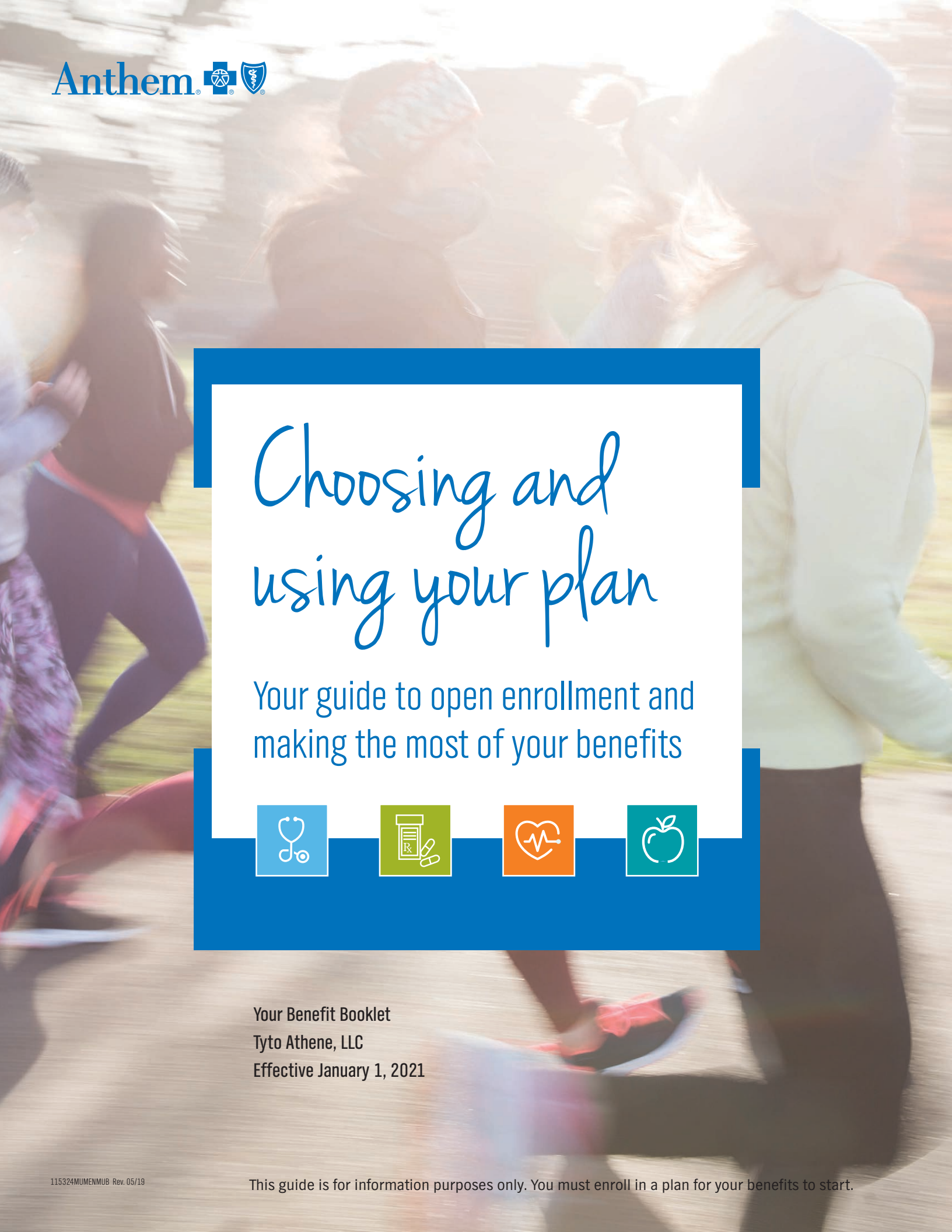


Anthem

Choosing and using your plan

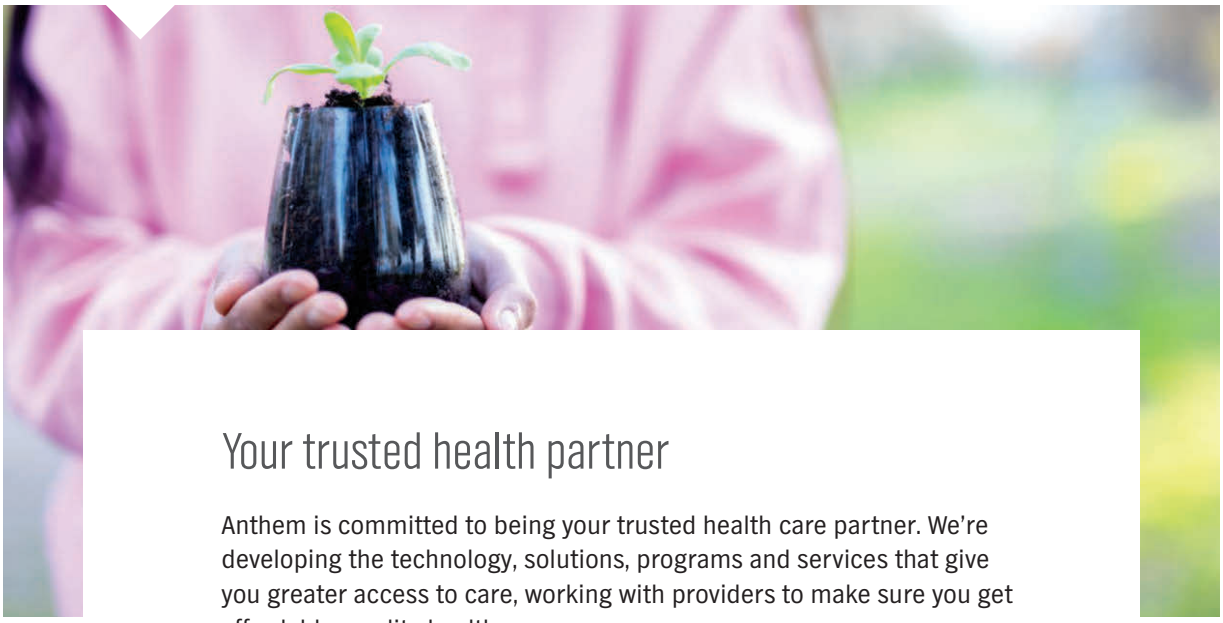
Your guide to open enrollment and making the most of your benefits

Your Benefit Booklet
Tyto Athene, LLC
Effective January 1, 2021

115324MUMENMUB Rev. 05/19

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

It’s time to choose your plan



Your trusted health partner

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

Save this guide

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

Time to choose your plan

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

Thinking about your health may not always be the first thing on your mind. But now is the right time to think about where you are and where you want to be in the future. It's your opportunity to check out the benefits, programs, and resources that can support your health and well-being all year long.

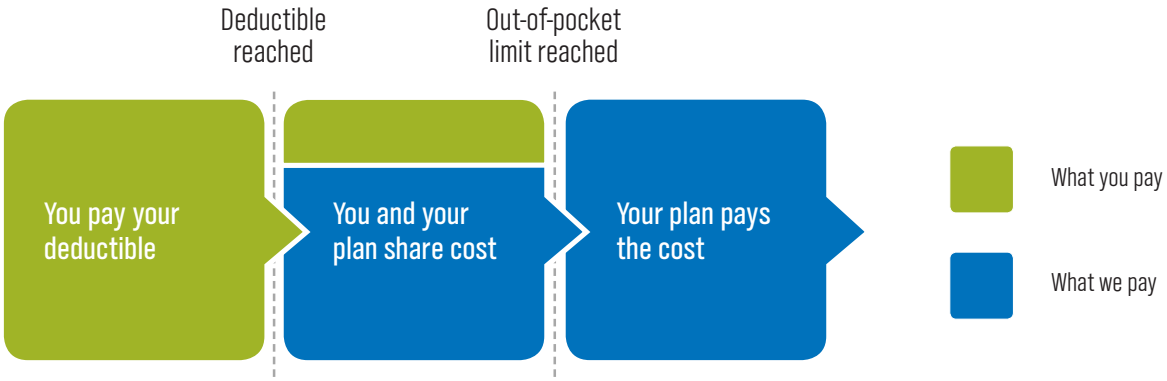
This guide will help you understand our plans and choose the one that is right for you. It's also full of tips, tools, and resources that can help you reach your health and wellness goals when you become a member. Keep it handy to make the most of your benefits throughout the year.

Table of contents

The basics of your health plan

Before going into the plan details, it may be helpful to review the following health benefit basics.

What you pay and what your plan pays



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

Understanding health care terms

To help you manage your health plan, see the following for definitions of common terms:

Deductible:

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

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

Copay:

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

Coinsurance:

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

Out-of-pocket limit:

This is the most you have to pay out of your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. There are plans that still have you pay a copay at the time of service.

Premium:

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

Explore your plan options

Look at the plans, and find the one that works best for you and your family.

PPO

With a preferred provider organization (PPO), you can go to almost any doctor or hospital and you're covered — giving you added choices and flexibility. You receive special rates for doctors in your plan, which lowers your out-of-pocket costs.

PPO highlights:

- You can choose a primary care doctor from the plan for preventive care, such as checkups and screenings.
- You don't 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 don't need to visit your primary care doctor first for a referral. This can save you time and a copay.
- You will pay less if you use doctors who are part of the PPO.
- You can see providers who aren't part of the PPO, but the cost is higher.
- Once you pay your deductible, you'll pay a percentage of the total cost (also called "coinsurance") anytime you receive care for a covered service. Your plan will cover the rest.

Health Savings Account

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

- Once you pay your deductible, you'll pay a percentage of the total cost (also called "coinsurance") anytime you receive care for a covered service. Your plan will cover the rest.
- All the money in your HSA rolls over from year to year, and it's yours even if you change health plans or jobs or retire.
- The money you put into your HSA, any interest you earn, and even the money you take out to pay for health care is all tax-free.
- You can contribute up to $3,600 for an individual and $7,200 for a family.[1]
- If you are 55 or older, you can contribute an extra $1,000 a year.

Watch our HSA Basics video for details.

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

Your pharmacy benefits

What your plan will cover

Your pharmacy plan includes:

- Different drug lists. Be sure to check the lists for your medicines, the brand-name drugs, and the generics that are included in your plan.
  - Visit **anthem.com/va/essentialdruglist** for the **Essential 4-tier** Drug List.

How your pharmacy benefits work

Your annual deductible

Before your plan starts to help pay for medicine, you first pay a set amount for covered medical care and drug costs out of your pocket. This is your combined medical and pharmacy deductible.

What you pay after meeting your deductible

After you meet your deductible, your plan will share the cost of medicine. Your options include plans with different ways of sharing the cost:

- **Copays:** You pay a set amount, or "copay," for medicine. Your copay will be based on which tier the drug is in. See "Save money with Tier 1 drugs" for details.
- **Coinsurance:** You pay a certain percentage of the drug's cost, which can be different based on the pharmacy you use.

Once you're a member, you can check the price of a drug at different pharmacies on **anthem.com** and see if there are lower-cost drugs.

Your pharmacy benefits

Save money with Tier 1 drugs

Prescription medicines or drugs are listed in groups called tiers. Your cost is based on which tier the drug is in. Tiers 1 and 2 usually include low-cost and generic drugs. You'll save the most money when you use Tier 1 drugs.

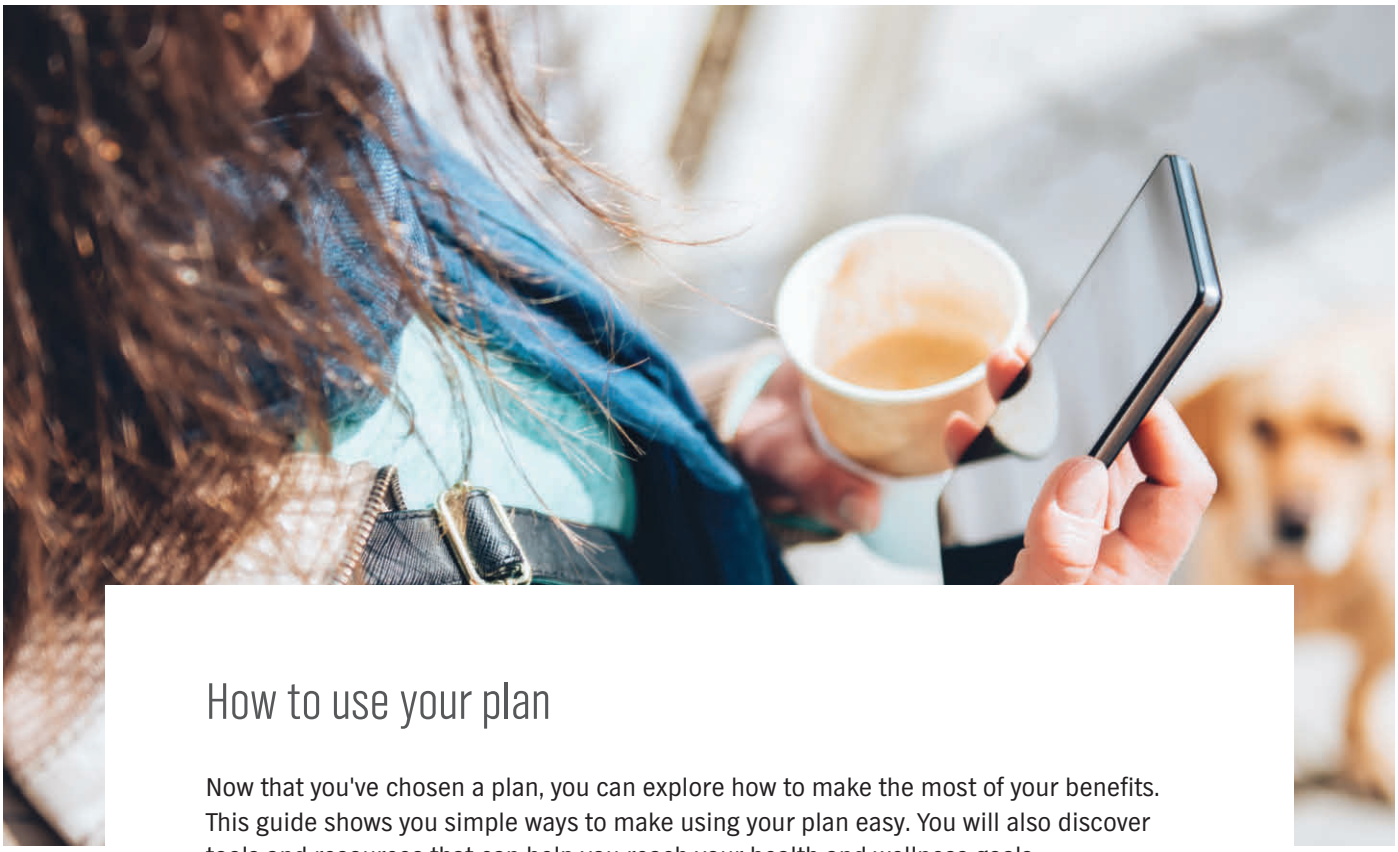
Once you're a member, you can check the price of a drug at different pharmacies at **anthem.com** and see if there are lower-cost drugs available.

	Drug type	Cost
Tier 1	Preferred generic	$
Tier 2	Preferred brand name and newer, more expensive generic drugs	$$
Tier 3	Nonpreferred brand name and generic drugs	$$$
Tier 4	Preferred specialty drugs (brand name and generic)	$$$$

Simple ways to save money on medicine

- Use home delivery for drugs you take on a regular basis. It may save you money, and there is no cost for standard shipping.
- Find a pharmacy in your plan.
- Talk to your doctor about generic medicines.
- See if an over-the-counter option is available.

Using your plan



How to use your plan

Now that you've chosen a plan, you can explore how to make the most of your benefits. 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. It's easy to share it with your doctor or pharmacy: print a copy anytime you need one, or email or fax it from your computer or mobile device. You also can download your ID card for quick access.

Register for online tools and resources

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

- Quickly access your digital ID card.
- Find a doctor and estimate your costs before you go.
- Look at your prescription drug benefits, check the price of a drug, and find a pharmacy near you that's in your plan.
- View your claims, see what's covered, and what you may owe for care.
- Check your spending account balances.
- Find support managing your health conditions and tracking your goals.
- Update your email and communication preferences.

How to use your plan

Find a doctor in your plan

The right doctor can make all the difference — and choosing one in your plan can save you money, as well. Your plan includes a broad range of top quality doctors. If you decide to receive care from doctors outside the plan, the cost will be higher and your care might not be covered at all.

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

Schedule a checkup

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

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

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

How to use your plan

See a doctor from home

You can have a video visit with a doctor using your mobile device or computer, whether you're at home, at the workplace, or on the go. Doctors are available around the clock for advice, treatment, and prescriptions.[1] 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's an emergency, call 911 or go to the nearest emergency room. If you need non-emergency 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 the 24/7 NurseLine and receive helpful advice from a registered nurse.

1 Online prescribing only when appropriate based on physician judgment. LiveHealth Online is the trade name of Health Management Corporation.

Make the most of your pharmacy benefits

You can manage your prescriptions and costs at **anthem.com**. Simply log in and explore the following ways to save:

1. **Search the drug list.** Find out if your drugs are covered and which tier they're in. Lower-cost drugs and generics are usually in Tiers 1 and 2. You'll save the most money when you use Tier 1 drugs.
2. **Price a medication.** See how much a medicine costs. You can compare retail drug costs at local pharmacies and see the price of generic options. Results will include the cost of up to a 90-day supply and home delivery pricing.
3. **See if there are generic options.** If you're taking a brand-name drug, you can find a list of generic options that cost less, or ask your doctor.
4. **Choose a pharmacy that's in your plan.** You have many retail pharmacies from which to choose. Use a pharmacy that is in your plan to avoid paying full price. To find a pharmacy in your plan, visit **anthem.com/pharmacyinformation/rxnetworks.html** and choose your network list. Your plan uses the National Network list of pharmacies.
5. **Save time with home delivery.** If you take medicines regularly or need them on a long-term basis, you can save time with home delivery. You may also save money. You can receive a 90-day supply of your drugs delivered to your door. Maintenance medicines can vary in amounts. Once you're a member, visit **anthem.com** to sign up.
6. **Receive a 90-day refill at a retail pharmacy.** You can receive up to a 90-day supply of any covered medicine at a participating retail pharmacy. Maintenance medicines can vary in amounts.

For questions about your pharmacy benefits, call the Pharmacy Member Services phone number on your member ID card, available 24/7.

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

Plan extras that support your health

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

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 at **anthem.com** or use the **Sydney Health** mobile app.

Apps

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

If you have a question, **Sydney Health** acts as a personal health guide, answering your questions and connecting you to the right resources at the right time. You can use the chatbot to receive answers quickly. **Sydney Health** makes it easier to manage your care, giving you time to focus on your health. Start now by downloading the **Sydney Health** mobile app.

Anthem Skill — Our new Anthem skill for Alexa is a voice-activated assistant for your health plan. Receive quick answers to your health care questions — hands-free. All you have to do is enable 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.
- Access your health savings account (HSA) or health reimbursement account (HRA) balance, if you have one.
- 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.
- Refill, renew, and check the order status of any home delivery prescriptions.

If you don't have the Amazon Alexa app, download it today 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 providers in your area. Simply call **800-337-4770**.

ConditionCare — Receive support from a dedicated nurse team to manage ongoing conditions, such as asthma, chronic obstructive pulmonary disorder

Are you looking for healthy advice?

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

Plan extras that support your health

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

(COPD), diabetes, heart disease, or heart failure. Work with dietitians, health educators, and pharmacists who can help you learn about your condition and manage your health.

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

LiveHealth Online — At home, at the workplace, or on the go, you can have a video visit with a doctor using your mobile device or computer. Doctors are available 24/7 for advice, treatment, and prescriptions, if needed.* The cost is usually $59 or less, depending on your health plan. Register at **livehealthonline.com**.

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

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 3REJ

Your Plan: Modified Anthem KeyCare 30 1000/20%/4000 Rx $15/$50/$85/20%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,000 person / $2,000 family	$2,000 person / $4,000 family
Out-of-Pocket Limit	$4,000 person / $8,000 family	$8,000 person / $16,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Enhanced Personal Healthcare Provider Office Visit	$10 copay per visit medical deductible does not apply	Not Applicable
Specialist Care Visit	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).*	$10 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$10 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services **Lab:**		
Office	No charge	40% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	40% 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	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray:		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Facility visit:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Surgical Center	$300 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation services: Office *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.*	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital *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.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National with R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$85 copay per prescription, deductible does not apply (retail) and $213 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $300 per prescription, deductible does not apply (retail and home delivery)	40% 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
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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

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

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: TBD

Your Plan: Modified Anthem KeyCare 30 1000/20%/4000 Rx $15/$50/$85/20%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$3,000 person / $6,000 family
Out-of-Pocket Limit	$4,000 person / $8,000 family	$8,000 person / $16,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Enhanced Personal Healthcare Provider Office Visit	$10 copay per visit medical deductible does not apply	Not Applicable
Specialist Care Visit	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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Other Practitioner Visits:		
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Prescription Drugs - *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Diagnostic Services **Lab:**		
Office	No charge	40% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	40% 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	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray:		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Facility visit:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Freestanding Surgical Center	$300 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Doctor and other services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation services: Office *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.*	$15 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital *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.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National with R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$85 copay per prescription, deductible does not apply (retail) and $213 copay per prescription, deductible does not apply (home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $300 per prescription, deductible does not apply (retail and home delivery)	40% 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
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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

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

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 3REH

Your Plan: Modified Anthem KeyCare 30 2000/30%/4500 Rx $15/$50/$85/20%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,000 person / $4,000 family	$4,000 person / $8,000 family
Out-of-Pocket Limit	$4,500 person / $9,000 family	$9,000 person / $18,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Doctor Home and Office Services		
Primary Care Visit	$15 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Enhanced Personal Healthcare Provider Office Visit	$10 copay per visit medical deductible does not apply	Not Applicable
Specialist Care Visit	$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$15 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution. (www.livehealthonline.com).*	$10 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$15 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$15 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Services in an Office:		
Allergy Testing	$10 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs - *Dispensed in the office*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Diagnostic Services **Lab:**		
Office	No charge	50% coinsurance after medical deductible is met
Preferred Reference Lab	No charge	50% 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	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
X-Ray:		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging:		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care	$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services	30% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	30% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Facility visit:		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Facility Fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor Services	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Surgical Center	$350 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Doctor and Other Services:		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and other services	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Rehabilitation services: Office *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.*	$15 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Outpatient Hospital *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.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospice	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Durable Medical Equipment	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National with R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $125 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$85 copay per prescription, deductible does not apply (retail) and $213 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $300 per prescription, deductible does not apply (retail and home delivery)	50% 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
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have a visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.

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

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Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Contract Code: 3REG

Your Plan: Anthem Modified HSA 2800/20%/4000 Rx $15/$50/$85/20%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,800 person / $5,600 family	$5,400 person / $10,800 family
Out-of-Pocket Limit	$4,000 person / $8,000 family	$8,000 person / $16,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred Reference Lab	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services	20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services:		
Office *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.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *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.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National with R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription after deductible is met (retail) and $38 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription after deductible is met (retail) and $125 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$85 copay per prescription after deductible is met (retail) and $213 copay per prescription after deductible is met (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $300 per prescription	40% coinsurance after deductible is met

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

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- 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" which is generally coinsurance or coinsurance after your deductible is met.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.

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

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Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your Contract Code: TBD

Your Plan: Modified Anthem HSA 3000/20%/5500 Rx $10/$40/$70/20%

Your Network: KeyCare

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 person / $6,000 family	$6,000 person / $12,000 family
Out-of-Pocket Limit	$6,900 person / $13,800 family	$13,800 person / $27,600 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prenatal and Post-natal Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	30% coinsurance after deductible is met	50% coinsurance after deductible is met
On-line Visit *Includes Mental Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Preferred Reference Lab	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
Ambulance	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility Visit:		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services:		
Office *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.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *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.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National with R90* *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription after deductible is met (retail) and $38 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription after deductible is met (retail) and $125 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$85 copay per prescription after deductible is met (retail) and $213 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	20% coinsurance up to $300 per prescription	50% coinsurance after deductible is met

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

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.		
Child Vision exam *Limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Adult Vision exam *Limited to 1 exam per benefit period.*	$15 copay	Reimbursed Up to $30

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- 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" which is generally coinsurance or coinsurance after your deductible is met.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.

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

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

Choose an easier way to better health

Health and wellness programs designed for your unique needs

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

ConditionCare

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

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

Future Moms

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

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

24/7 NurseLine

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

These nurses can:

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

Get the support you need

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

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

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Looking for easy?

Try our home delivery pharmacy.

If one less thing to do in your day sounds good, you can get your prescription medicines delivered to your home instead of picking them up at the pharmacy. It's easy to set up home delivery for the prescriptions you take long-term for conditions like diabetes or asthma. You'll get a 90-day supply with free standard shipping. And it may save you money.

Your health plan is all about giving you choices. So when you need a prescription medicine, you can choose home delivery, you can keep getting your prescriptions at your local pharmacy, or you can get 90-day supplies from a CVS pharmacy. When you choose CVS, you can get many maintenance and non-maintenance drugs on your drug list at the same home delivery copay. It's up to you. You just need to let us know what you want to do. You'll be able to get your prescriptions filled at your local pharmacy two times — the first fill plus one refill — before you let us know your choice. After that, you'll have to pay the full cost for your medicines until you contact us.

When you get your medicines at your local pharmacy, we'll send you a letter to let you know you need to contact us with your choice and tell you about home delivery, how it works and cost savings you may see.

With home delivery, you get:

Savings

Many medicines cost less when you get a 90-day supply instead of three 30-day supplies.

Convenience

You can skip the trip to the pharmacy. First-time home delivery orders take about two weeks, and refills take 3 to 5 days. You can set up automatic refills, too.

Peace of mind

You'll be less likely to miss a dose and more likely to stay on track with the treatment your doctor prescribed.*

Two easy ways to switch:

1. You can let us know your choice after your final courtesy fill at the pharmacy online at **anthem.com** or through the Sydney app. Just visit the pharmacy page after you log in. You can also refill your prescriptions, find a pharmacy, see what's covered and even price drugs before you get them.
2. Or you can call us at the Pharmacy Member Services number on your health plan ID card.

Still have questions?

Call us at the Pharmacy Member Services number on your health plan ID card.

* Schwab P, Racsa P, Rascati K, Mourer M, Meah Y, Worley K. *A Retrospective Database Study Comparing Diabetes-related Medication Adherence and Health Outcomes for Mail-order versus Community Pharmacy.* J Manag Care Spec Pharm 2019 Mar;25(3):332-40: ncbi.nlm.nih.gov/pubmed/30816817.

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The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

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

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

Special enrollment periods

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

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

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

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

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

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

When you're covered by more than one plan

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

Determining the primary and secondary plans

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

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

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered (PPO)

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

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

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

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

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    This Exclusion does not apply to:

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

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

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

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

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

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

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

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

21) **Dental Treatment** Dental treatment, except as listed below.

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

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

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

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

22) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

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

24) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

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

26) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

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

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

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

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

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

30) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.

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

32) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

33) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

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

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

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

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

35) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

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

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

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

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

39) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

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

41) **Home Care**

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

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

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

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

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

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

46) **Maintenance Therapy** Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

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

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

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

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

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

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

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

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

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

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

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

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

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

55) **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.

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 health care. To understand howwe protect your privacy, your rights and responsibilities when receiving health care, and your rights under the Women's Health and Cancer Rights Act, go to **anthem.com/privacy**. 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 health care professionals who work with you and your doctor to help you manage your health conditions. They also help you better understand your health benefits.

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

Special enrollment rights

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

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

— You (or your eligible dependents) lose Medicaid or the State Children's Health Insurance Program (SCHIP) benefits because you're no longer eligible..

— You (or eligible dependents) become eligible to receive help from Medicaid or SCHIP for paying part of the cost of a health plan with us.

For full details, read your plan documents, which contain everything you need to know about your plan. You can find them on **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**.

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Are you ready to use your plan?

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.

Anthem

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