



# Choosing and using your plan

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

**Pittsylvania County and Schools**

**Effective October 1, 2024**



# Time to choose your plan

## Your trusted health partner

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



# Time to choose your plan

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

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

This guide was created to help you understand our plans. It also has tips, tools, and resources that can help you reach your health and wellness goals when you become a member.

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# Explore your plan options

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

## KeyCare 30

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

- You can choose a primary care doctor from the plan's network for preventive care, such as checkups and screenings.
- You do not need to have a primary care doctor to see a specialist.
- When you want to see a specialist, such as an orthopedic doctor or a cardiologist, you do not need to visit your primary care doctor first for a referral. This can save you time and a copay.
- You'll pay less if you choose doctors and facilities in your plan

## Health savings account (HSA)

An HSA allows you to set aside pretax dollars to pay for care when you need it. You can use money in the account to pay for qualified medical expenses, such as hospital visits, prescription drugs, or copays for a doctor visit.<sup>1</sup>

- The money you put into your HSA, any interest you earn, and the money you take out to pay for healthcare is tax-free.
- You can contribute up to \$4,150 for an individual and \$8,300 for a family.
- If you are 55 or older, you can contribute an extra \$1,000 a year.

<sup>1</sup> For a full list of qualified expenses for an individual, visit [qme.anthem.com](https://www.qme.anthem.com).

<sup>2</sup> Veterans who have received medical benefits from Veterans Affairs 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](https://www.irs.gov/irb/2004-33_IRB) for details.

# Using your plan



## How to use your plan

Once you become a member, explore how to make the most of your benefits . This guide shows you ways to make using your plan easier. You will also discover tools and resources that can help you reach your health and wellness goals.



# How to use your plan

## Register for online tools and resources

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

### Sydney Health mobile app

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

### Working with you:

- Reminding you about important preventive care needs.
- Guiding you with insights based on your history and changing health needs.
- Empowering you with personalized resources to find and compare doctors and check costs.

### Working for you:

- **Chat** - If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.
- **Virtual Care** - Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.
- **Community Resources** - This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

## Use your ID card from your phone

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

## Find a doctor in your plan

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

To find a healthcare professional or facility in your plan's network, use the **Find Care** tool on the **Sydney Health** mobile app or at **anthem.com**. You can search for doctors, hospitals, pharmacies, and high-quality labs such as Quest Diagnostics and Labcorp.

# How to use your plan

## Schedule a checkup

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

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

## Travel with peace of mind

Your health plan goes with you when you're away from home and need care immediately. The BlueCard program gives you access to services across the country. This includes 1.7 million doctors and hospitals with Blue Cross Blue Shield companies.<sup>1</sup> If you're traveling out of the country, you can receive care through the Blue Cross Blue Shield Global Core program. It gives you access to doctors and hospitals in more than 190 countries and territories around the world.<sup>2</sup>

If you need care in the U.S., go to **anthem.com**. When you're outside the U.S., visit **bcbsglobalcore.com** or download the BCBS Global Core mobile app. You also can call Blue Cross Blue Shield Global Core 24/7 at 011-800-810-BLUE (2583) or call collect by dialing 0170 and telling the operator you want to call 011-804-673-1177.

If you have questions about travel benefits, call the Member Services number on your ID card before you leave home.

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

When it is an emergency, call 911 or go to the nearest emergency room. If you need nonemergency care right away:

- Check to see if your primary care doctor can see you.
- Search for nearby urgent care to avoid costly emergency room visits and long wait times.
- Have a virtual chat with your doctor from your mobile device or computer.

<sup>1</sup> Blue Cross Blue Shield Association, Personalized Healthcare, Nationwide (accessed March 2023): [bcbs.com](https://www.bcbs.com).

<sup>2</sup> GeoBlue, More than 20 years as a leader in international healthcare (accessed March 2023): [about-geo-blue.com](https://www.about-geo-blue.com).

<sup>3</sup> If you have a high-deductible health plan and have not met your deductible, the price of a visit will be \$39, starting on the date in 2023 your plan renews.

Other virtual care services offered through an arrangement with LiveHealth Online.

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

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

You may also receive a bill for any charges not covered by your health plan.

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 49EH

Your Plan: Pittsylvania County and Schools: Anthem KeyCare

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge
<b>Specialist care</b>	\$30 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$1,500 person / \$3,000 family	\$2,000 person / \$4,000 family
<b>Overall Out-of-Pocket Limit</b>	\$6,500 person / \$13,000 family	\$13,000 person / \$26,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

**Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$30 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
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p> <p>\$30 copay per visit medical deductible does not apply</p> <p>\$25 copay per visit medical deductible does not apply</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>X-Ray</b> Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i> Office Outpatient Hospital	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i> <b>Emergency Room Facility Services</b> <b>Emergency Room Doctor and Other Services</b> <b>Ambulance</b>	\$30 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b> Facility Fees Doctor Services	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% 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
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services <i>including surgeon fees</i></b></p> <p>Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services <i>including surgeon fees</i></b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i></b> <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Pulmonary rehabilitation <i>office and outpatient hospital</i></b></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	No charge	40% coinsurance after medical deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Hearing Aids</b> <i>Coverage is limited to 1 item per ear up to \$1,500 per ear, every 24 months for members through age 18.</i>	No charge	20% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>Essential Drugs not included on the Essential drug list will not be covered.</i></b>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy 30 day supply (cost shares noted below)</b>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</p> <p><b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</p> <p><b>Specialty Pharmacy</b> 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.</p>		
<b>Tier 1 - Typically Generic</b>	\$10 copay per prescription (retail) and \$25 copay per prescription (home delivery)	\$10 copay per prescription (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b>	\$40 copay per prescription (retail) and \$100 copay per prescription (home delivery)	\$40 copay per prescription (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$60 copay per prescription (retail) and \$150 copay per prescription (home delivery)	\$60 copay per prescription (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	20% coinsurance up to \$250 per prescription (retail and home delivery)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>This is a brief outline of your vision coverage. Only children's vision services count towards your out-of-pocket limit.</i></p>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30

**Notes:**

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".

- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

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

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

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

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## Language Access Services:

### Get help in your language

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

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956

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

(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 592-9956

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 592-9956。

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

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

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

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

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

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiłlnih (833) 592-9956.



## Language Access Services:

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

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

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

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

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

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

### It's important we treat you fairly

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

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Contract Code: 49EG

Your Plan: Pittsylvania County and Schools: Anthem HSA Embedded

Your Network: KeyCare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge after deductible is met
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge after deductible is met
<b>Specialist care</b>	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$3,500 person / \$7,000 family	\$3,500 person / \$7,000 family
<b>Overall Out-of-Pocket Limit</b>	\$4,500 person / \$9,000 family	\$7,000 person / \$14,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).

In-Network and Non-Network deductibles are combined and accumulate toward each other; however In-Network and Non-Network out-of-pocket limit amounts accumulate separately and do not accumulate toward each other.

**Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	No charge after deductible is met	20% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	No charge after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 30 visits per benefit period.</i></p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Preferred Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	No charge after deductible is met	20% coinsurance after deductible is met
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b> <b>Emergency Room Facility Services</b> <b>Emergency Room Doctor and Other Services</b> <b>Ambulance</b>	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b> Facility Fees Doctor Services	No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u><b>Outpatient Surgery</b></u> <b>Facility Fees</b> Hospital Ambulatory Surgical Center <b>Physician and other services including surgeon fees</b> Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met
<u><b>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</b></u> <b>Facility Fees</b> <b>Physician and other services including surgeon fees</b>	No charge after deductible is met No charge after deductible is met	20% coinsurance after deductible is met 20% coinsurance after deductible is met
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i>	No charge after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  <i>Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge after deductible is met</p> <p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b>  <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 100 days combined per admission.</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p><b>Hearing Aids</b>  <i>Coverage is limited to 1 item per ear up to \$1,500 per ear, every 24 months for members through age 18.</i></p>	<p>No charge after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Pharmacy Deductible</b></p>	<p>Combined with In-Network medical deductible</p>	<p>Combined with Non-Network medical deductible</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <b>Network: Base Network</b> <b>Drug List: Essential</b> <i>Drugs not included on the Essential drug list will not be covered.</i>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i> <b>Retail 90 Pharmacy</b> <i>90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).</i> <b>Home Delivery Pharmacy</b> <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.</i> <b>Specialty Pharmacy</b> <i>30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.</i>		
<b>Preventive Drugs</b> <i>No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRX Enhanced drug list when you use an In-Network Pharmacy.</i>		
Tier 1 - Typically Generic	\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	\$10 copay per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	\$40 copay per prescription after deductible is met (retail) and \$100 copay per prescription after deductible is met (home delivery)	\$40 copay per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription after deductible is met (retail) and \$150 copay per prescription after deductible is met (home delivery)	\$60 copay per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to \$250 per prescription after deductible is met (retail and home	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	delivery)	

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out-of-pocket limit.</i>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	\$15 copay deductible does not apply	Reimbursed Up to \$30

**Notes:**

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

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

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

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

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## Language Access Services:

### Get help in your language

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

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 592-9956

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

(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 592-9956

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 592-9956:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 592-9956。

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 592-9956 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 592-9956.

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

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

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

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

**Navajo (Diné):** Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí ła' bich'í' hadeesdzih nínízingo kojí' hodiłlnih (833) 592-9956.

## Language Access Services:

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

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

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

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# PreventiveRx Enhanced Drug List

## Enhanced Plan (Essential Drug List)

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

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

Brand-name drugs that have a generic equivalent available are not covered under this PreventiveRx benefit.

Not all drugs on this list may be covered by your plan. Some drugs, such as those used for cosmetic purposes, may be excluded from your benefits. Please refer to your Certificate or Evidence of Coverage for coverage limitations and exclusions.

Please note: The drug list is subject to change and all previous versions of the drug list are no longer in effect.

### ASTHMA

albuterol sulfate  
nebulization solution,  
syrup, tablets  
albuterol sulfate HFA  
Arnuity Ellipta  
Breo Ellipta  
breyna  
budesonide inhalation  
suspension  
budesonide/formoterol  
aerosol  
cromolyn nebulization  
solution  
elixophyllin  
Flovent Diskus  
Flovent HFA  
fluticasone HFA  
fluticasone diskus (generic  
for Flovent Diskus)  
fluticasone/ salmeterol HFA  
(generic for Advair HFA)  
fluticasone/ salmeterol  
powder (generic for Advair  
Diskus)  
fluticasone/ salmeterol  
powder (generic for Airduo  
RespiClick)  
fluticasone/ vilanterol  
formoterol nebulization  
solution\*  
levalbuterol nebulization  
solution\*  
levalbuterol HFA  
montelukast  
ProAir RespiClick  
QVAR RediHaler  
Serevent Diskus  
Spiriva Respimat  
terbutaline injection, tablets

Theo- 24  
theophylline elixer, solution  
theophylline ER  
Trelegy Ellipta  
wixela inhub  
zafirlukast

### BLOOD CLOTS AND STROKE

aspirin- dipyridamole ER  
Brilinta  
cilostazol\*  
clopidogrel bisulfate  
dipyridamole\*  
Eliquis  
heparin\*  
jantoven  
prasugrel\*  
warfarin  
Xarelto

### DIABETES

*{Diabetic supplies including  
blood glucose meters, test  
strips and lancets require  
a prescription to be  
covered by this plan. Only  
blood glucose meters &  
blood glucose test strips  
for OneTouch and Accu-  
Chek products will be  
covered by this benefit.  
Continuous Glucose  
Monitors (CGMs) are not  
included in PreventiveRx  
Coverage.*

acarbose  
alogliptin  
alogliptin/metformin  
alogliptin/pioglitazone  
Farxiga

glimepiride  
glipizide  
glipizide er/xl  
glipizide/ metformin  
glyburide  
glyburide/ metformin  
glyburide micronized  
Glyxambi  
Humalog  
Humalog Junior KwikPen  
Humalog KwikPen  
Humalog Mix 50/50  
Humalog Mix 50/50  
KwikPen  
Humalog Mix 75/25  
Humalog Mix 75/25  
KwikPen  
Humulin 70/30  
Humulin 70/30 KwikPen  
Humulin N  
Humulin N KwikPen  
Humulin R  
Humulin R KwikPen  
Insulin Glargine  
Insulin Glargine Solostar  
Insulin Lispro  
Insulin Lispro Junior  
KwikPen  
Insulin Lispro KwikPen  
Insulin Lispro Protamine  
Janumet  
Janumet XR  
Januvia  
Jardiance  
Lantus  
Lantus Solostar  
Lyumjev  
Lyumjev KwikPen

metformin (500 mg, 850 mg,  
1000 mg)  
metformin ER (Generic for  
Glucophage XR)  
miglitol  
Mounjaro  
nateglinide\*  
Ozempic  
pioglitazone  
pioglitazone/ glimepiride  
pioglitazone/ metformin  
repaglinide\*  
Rybelsus  
Soliqua  
SymlinPen  
Synjardy  
Synjardy XR  
Toujeo Max  
Toujeo SoloStar  
Tresiba  
Tresiba Flextouch  
Trijardy XR  
Trulicity  
Victoza  
Xigduo XR  
Xultophy

### HEART HEALTH AND HIGH BLOOD PRESSURE

acebutolol  
acetazolamide  
acetazolamide ER  
amiloride\*  
amiloride/ hctz  
amlodipine besylate  
amlodipine/ benazepril  
amlodipine/ olmesartan  
amlodipine/ valsartan  
amlodipine/ valsartan/ hctz  
atenolol

# PreventiveRx Enhanced Drug List

## Enhanced Plan (Essential Drug List)

atenolol/ chlorthalidone  
benazepril  
benazepril/ hctz  
betaxolol  
bisoprolol fumarate  
bisoprolol fumarate/ hctz  
bumetanide  
candesartan  
candesartan/ hctz  
captopril  
captopril/ hctz  
cartia XT  
carvedilol  
carvedilol ER\*  
chlorthalidone  
clonidine patch\*  
clonidine tablets  
digitek  
digox  
digoxin  
diltiazem CD  
diltiazem  
diltiazem ER  
dilt-XR  
doxazosin  
enalapril  
enalapril oral solution\*  
enalapril/ hctz  
eplerenone\*  
ethacrynic acid tablets\*  
felodipine ER  
fosinopril sodium  
fosinopril/ hctz  
furosemide  
guanfacine  
hydralazine  
hydrochlorothiazide  
indapamide  
irbesartan  
irbesartan/ hctz  
isosorbide dinitrate (5mg,  
10 mg, 20 mg, 30 mg)  
isosorbide dinatrate (40  
mg)\*  
isosorbide dinitrate/  
hydralazine  
isosorbide mononitrate  
isosorbide mononitrate ER  
isradipine

labetalol  
lisinopril  
lisinopril/ hctz  
losartan  
losartan/ hctz  
matzim LA  
methazolamide\*  
methyldopa  
metolazone  
metoprolol succinate ER  
metoprolol tartrate/ hctz  
metoprolol tartrate  
minoxidil  
moexipril  
nadolol\*  
nebivolol  
nicardipine  
nifedipine\*  
nifedipine ER\*  
nimodipine  
nisoldipine ER  
Nitro-Dur 0.3, 0.8mg/ hr  
nitroglycerin  
nitroglycerin 400 mcg  
spray\*  
nitroglycerin sublingual  
tablets  
olmesartan  
olmesartan/ hctz  
olmesartan/amlodipine/  
hctz  
perindopril  
pindolol\*  
prazosin  
propranolol  
propranolol ER  
quinapril  
quinapril/ hctz  
ramipril  
ranolazine ER\*  
sorine\*  
sotalol\*  
sotalol AF\*  
spironolactone  
spironolactone/ hctz  
taztia XT  
telmisartan  
telmisartan/ amlodipine  
telmisartan/ hctz

terazosin  
tiadylt  
timolol tablets  
torsemide  
trandolapril  
trandolapril/ verapamil  
triamterene\*  
triamterene/ hctz  
valsartan  
valsartan/ hctz  
verapamil  
verapamil ER  
verapamil SR

### HEART RATE AND RHYTHM

amiodarone  
disopyramide\*  
flecainide\*  
mexiletine\*  
Norpace CR  
pacerone  
propafenone\*  
propafenone ER\*  
quinidine  
quinidine ER  
quinidine CR

### HIGH CHOLESTEROL

atorvastatin  
atorvastatin/ amlodipine  
cholestyramine\*  
cholestyramine light  
colesevelam tablets\*  
colestipol  
ezetimibe\*  
ezetimibe/ simvastatin\*  
fenofibrate (43, 50, 67, 130,  
134, 150, 200 mg capsules  
& 48, 54, 145, 160 mg  
tablets)  
fenofibric acid  
fluvastatin  
gemfibrozil  
lovastatin  
niacin ER  
pravastatin  
prevalite\*  
rosuvastatin\*  
simvastatin

### MALARIA

atovaquone/proguanil  
chloroquine  
hydroxychloroquine  
mefloquine  
primaquine

### MENTAL HEALTH

amitriptyline  
amoxapine  
aripiprazole\*  
aripiprazole ODT\*  
bupropion  
bupropion SR  
bupropion XL  
carbamazepine  
carbamazepine ER  
chlorpromazine  
citalopram  
clomipramine  
clozapine\*  
clozapine ODT\*  
desipramine\*  
desvenlafaxine ER  
Dilantin  
divalproex sodium DR, ER  
Doxepin  
duloxetine\*  
Epitol  
escitalopram  
ethosuximide  
felbamate\*  
fluoxetine capsules, tablets,  
solution  
fluoxetine DR  
fluphenazine  
flvoxamine  
flvoxamine ER  
gabapentin\*  
haloperidol solution, tablets  
imipramine capsules,  
tablets  
lamotrigine  
lamotrigine chewable  
lamotrigine ER  
lamotrigine ODT  
levetiracetam\*  
levetiracetam ER\*  
lithium

# PreventiveRx Enhanced Drug List

## Enhanced Plan (Essential Drug List)

lithium ER	tranylcypromine	raloxifene
loxapine	trazodone	risedronate
mirtazapine	trifluoperazine	risedronate DR
mirtazapine ODT	trimipramine	
molindone*	valproic acid	
nefazodone	venlafaxine	
nortriptyline	venlafaxine ER 225	
olanzapine*	mg tablets	
olanzapine ODT*	venlafaxine ER	
olanzapine/ fluoxetine	capsules	
oxcarbazepine	ziprasidone*	
paliperidone ER*	zonisamide*	
paroxetine	<b>OSTEOPOROSIS</b>	
paroxetine ER	alendronate sodium	
perphenazine	amabelz	
phenelzine	calcitonin- salmon*	
phenytek	Climara Pro	
phenytoin	Combipatch	
phenytoin chewable	dotti	
phenytoin infatabs	estradiol tablets,	
phenytoin ER	patch, gel	
pregabalin*	estradiol/ norethindrone	
primidone	acetate	
prochlorperazine	Fosamax Plus D	
protriptyline*	Fyavolv	
quetiapine*	ibandronate sodium	
quetiapine ER*	tablets	
risperidone tablets, solution	jinteli	
risperidone ODT*	lyllana	
roweepra*	mimvey	
sertraline	medroxyprogesterone	
subvenite	acetate	
thioridazine	Menest	
thiothixene	norethindrone-ethinyl	
tiagabine*	estradiol	
topiramate	Premarin tablets	
topiramate ER	Premphase	
	Prempro	

\* Indicates tier 2 generic drugs. Lower case drug names are generics and will be tier 1 unless otherwise noted with \*. Upper case drug names indicate brand drugs, which are tier 2. Tier status indication is meant to be used as guide and may not represent true status on formulary/drug list. Formularies are subject to change.

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

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc., Anthem Blue Cross and Blue Shield, and its affiliate HealthKeepers, Inc., serving all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123, are independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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## Get help in your language

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

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

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

### Spanish

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

### Chinese

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

### Vietnamese

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

### Korean

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

### Tagalog

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

### Russian

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

### Arabic

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

### Armenian

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

### Farsi

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

### French

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

#### Japanese

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

#### Haitian

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

#### Italian

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

#### Polish

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

#### Punjabi

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

#### Navajo

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

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

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

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

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice eye care doctors. Our network also has many convenient optical stores, including popular national retail stores LensCrafters®, TargetOptical®, and most Pearle Vision® locations. When you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. To locate a participating network eye care doctor or location, log in at [anthem.com](http://anthem.com), or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at the number on the back of your ID card.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
<b>Routine Eye Exam</b>			
A comprehensive eye examination	\$15 copay	Up to \$30 allowance	Once every calendar year

**USING YOUR BLUE VIEW VISION PLAN**

When you are ready to schedule your eye exam, just make an appointment with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network.

**ADDITIONALSAVINGS ON EYEWEAR AND MORE**

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

**OUT-OF-NETWORK**

If you choose to, you may receive covered services outside of the Blue View Vision network. If you choose an out-of-network doctor, you must pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance. To download a claim form, log in at [anthem.com](http://anthem.com), or from the home page menu locate Support and select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at the number on the back of your ID card to request a claim form. To request reimbursement for out-of-network services, complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below.

**To Fax:** 866-293-7373  
**To Email:** [oonclaims@eyewearspecialoffers.com](mailto:oonclaims@eyewearspecialoffers.com)  
**To Mail:** Blue View Vision  
 Attn: OON Claims  
 P.O. Box 8504  
 Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit [anthem.com](http://anthem.com) or call us at the number on the back of your ID card.

This information is only a brief outline of coverage and only one piece of your entire enrollment package. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview.



OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		Member Pays
<b>Retinal Imaging</b>	<ul style="list-style-type: none"> <li>At member's option can be performed at time of eye exam</li> </ul>	Not more than \$39
<b>Eyeglass Frame</b>	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*</li> </ul>	35% off retail price
<b>Eyeglass Lenses</b> Standard plastic material	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*:               <ul style="list-style-type: none"> <li>Single Vision \$50</li> <li>Bifocal \$70</li> <li>Trifocal \$105</li> </ul> </li> </ul>	
<b>Eyeglass Lens Options and Upgrades</b> When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eye glass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*:               <ul style="list-style-type: none"> <li>UV Coating \$15</li> <li>Tint (Solid and Gradient) \$15</li> <li>Standard Scratch-Resistant Coating \$15</li> <li>Standard Polycarbonate \$40</li> <li>Standard Anti-Reflective Coating \$45</li> <li>Standard Progressive Lenses (add-on to Bifocal) \$65</li> <li>Other Add-Ons</li> </ul> </li> </ul>	20% off retail price
<b>Conventional Contact Lenses</b> (non-disposable type)	<ul style="list-style-type: none"> <li>Discount applies to materials only</li> </ul>	15% off retail price

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

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

Some of the Blue View Vision participating in-network providers include:



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

Other savings offers are available on eyewear, hearing aids and even LASIK laser vision correction surgery through a variety of vendors. Just **log in at [anthem.com](http://anthem.com)**, select discounts, then Vision, Hearing & Dental.

# Employee Assistance Program Service Summary Pittsylvania County and Schools



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

Life can be full of challenges. Your Anthem Employee Assistance Program (EAP) is here to help you and your household members. EAP offers a wide range of **no-cost** support services and resources, including:



### Counseling

- Up to 4 visits per issue
- In-person or online visits
- Call EAP or use the online Member Center to initiate services



### Legal consultation

- 30-minute phone or in-person meeting
- Discounted fees to retain a lawyer
- Free legal resources, forms, and seminars online



### Financial consultation

- Phone meeting with financial professionals
- Regular business hours; no appointment required
- Free financial resources and budgeting tools online



### ID recovery

- Help reporting to consumer credit agencies
- Assistance with paperwork and creditor negotiations



### Emotional Well-being Resources

- Digital tools to improve emotional well-being
- Team up with an experienced clinical coach
- Practice mindfulness on the go



### Dependent care and daily living resources

- Online information about child care, adoption, elder care, and assisted living
- Phone consultation with a work-life specialist
- Help with pet sitting, moving, and other common needs



### Other anthemEAP.com resources

- Well-being articles, podcasts, and monthly webinars
- Self-assessment tools for emotional health issues



### Crisis consultation

- Toll-free emergency number; 24/7 support
- Online critical event support during crises

## We are ready to support you

You can call us at **800-346-5484**, or go to **anthemEAP.com** and enter your company code: **Pittsylvania County and Schools**

**When something unexpected happens, EAP can help you figure out your next steps. Contact us today.**

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

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

Language Access Services – (TTY/TDD: 711)

Spanish – Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda.

Chinese – 您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。

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

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Copies of Colorado network access plans are available on request from member services or can be obtained by going to [anthem.com/co/networkaccess](http://anthem.com/co/networkaccess). In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compare Health Services Insurance Corporation (Compare) or Wisconsin Collaborative Insurance Corporation (WCIC). Compare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

# Use your preventive care benefits

Stay healthy and catch problems  
early for easier treatment



Our health plans offer all the preventive care services and immunizations below at no cost to you.<sup>1</sup> As long as you use a doctor, pharmacy, or lab in your plan's network, you won't have to pay anything. If you go to doctors or facilities that are not in your plan, you may have to pay out of pocket.

If you are not sure which exams, tests, or shots are right for you, talk to your doctor.

## Preventive care vs. diagnostic care: Knowing the difference

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

## Adult preventive care

### General preventive physical exams, screenings, and tests (all adults):

- Alcohol and drug misuse: related screening and behavioral counseling
- Anxiety, depression, and suicide risk screenings
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet and physical activity
- High blood pressure (hypertension) screening
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels screening
- Colorectal cancer screenings, including fecal occult blood test, barium enema, flexible sigmoidoscopy (exam of the large intestine), screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)<sup>2</sup>
- Diabetes screening (type 2)<sup>3</sup>
- Exercise interventions to prevent falls in adults over age 65

- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hepatitis C virus (HCV) screening
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Human immunodeficiency virus (HIV): screening and counseling ;
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years<sup>2</sup>
- Obesity: related screening and counseling<sup>3</sup>
- Sexually transmitted infections: related screening and counseling
- Syphilis infection screening for persons who are at increased risk
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

### Women's preventive care:

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met<sup>5</sup>
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling<sup>6,7,8/9</sup>
- Chlamydia and gonorrhea screening
- Contraceptive (birth control) counseling
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Human papillomavirus (HPV) screening<sup>7</sup>
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, HIV, healthy weight, preeclampsia, and depression<sup>7</sup>
- Urinary incontinence screening
- Well-woman visits

### Immunizations:

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

The preventive care services listed above are recommendations of the Affordable Care Act (ACA) and are subject to change. They may not be right for every person. Ask your doctor what's right for you.

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the group policy provisions will rule. Please see your combined evidence of coverage (EOC) and disclosure form or certificate for exclusions and limitations.

## Child preventive care

### Preventive physical exams, screenings, and tests:

- Anemia screening
- Anxiety, depression, and suicide risk screenings
- Autism Spectrum Disorder (ASD) screening
- Blood pressure screening
- Cervical dysplasia (abnormal cell growth on the cervix) screening
- Cholesterol and lipid (fat) levels screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Hepatitis B screening
- HIV screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- Ocular prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive medication: newborns
- Oral (dental health) assessment, when done as part of a preventive care visit
- Sexually transmitted infections: related screening and counseling
- Skin cancer counseling for those ages 6 months to 24 years with fair skin
- Sudden cardiac arrest/death risk assessment
- Tobacco, alcohol, and drug use assessments
- Vision screening for those ages 6 months to 5 years



### Immunizations:

- Chickenpox
- Flu
- Haemophilus influenzae type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Respiratory syncytial virus (RSV)
- Rotavirus
- Severe acute respiratory syndrome coronavirus 2 (SARS CoV 2)(COVID-19)
- Whooping cough

## Coverage for pharmacy items

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

- Meet certain age requirements and other rules
- Receive and fill prescriptions from doctors, pharmacies, or other healthcare professionals in your plan's network
- Have prescriptions, including for OTC items

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

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria<sup>2</sup>
- Contraceptives, including generic prescription drugs and OTC items like female condoms and spermicides<sup>7,8</sup>
- Folic acid for women ages 55 or younger who are planning to become pregnant
- Low-dose aspirin (81 mg) for pregnant women who have an increased risk of preeclampsia

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

- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for members ages 45 to 75
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Preexposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for members ages 18 and older

### Child preventive drugs and other pharmacy items (age appropriate):

- Dental fluoride varnish to prevent tooth decay in children ages 5 and younger
- Fluoride supplements for children ages 6 and younger

If you'd like more help understanding your preventive care benefits, call the Member Services number on your health plan ID card. For a complete list of covered preventive drugs under the Affordable Care Act, view the *Preventive ACA Drug List* flyer, available at [anthem.com/pharmacyinformation](http://anthem.com/pharmacyinformation).

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

<sup>2</sup> You may be required to receive preapproval for these services.

<sup>3</sup> The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

<sup>4</sup> Some plans cover additional vision services. Please see your contract or certificate of coverage for details.

<sup>5</sup> Check your medical policy for details.

<sup>6</sup> Breast pumps and supplies must be purchased from suppliers or retailers in your plan's network for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

<sup>7</sup> This benefit also applies to those younger than age 19.

<sup>8</sup> You may pay a share of cost for other prescription contraceptives, based on your drug benefits. Your cost share may be waived if your doctor decides that using the multisource brand or brand name is medically necessary.

<sup>9</sup> Counseling services for breastfeeding (lactation) can be provided or supported by a doctor or facility in your plan's network, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay or coinsurance). Contact the provider to see if such services are available.

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# The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney<sup>SM</sup> Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

## Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

## My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

## Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

## Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

## Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

## My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

## ¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar [espanol.anthem.com](http://espanol.anthem.com).



## Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.



Scan the QR code to download the Sydney Health app.

You can also set up an account at [anthem.com/register](http://anthem.com/register) to access most of the same features from your computer.

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

Sydney Health is offered through an arrangement with Caredon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2023 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

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# Expanding your virtual care options

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

### Visit with a doctor at your convenience

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

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

### Assess your symptoms with the Symptom Checker

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

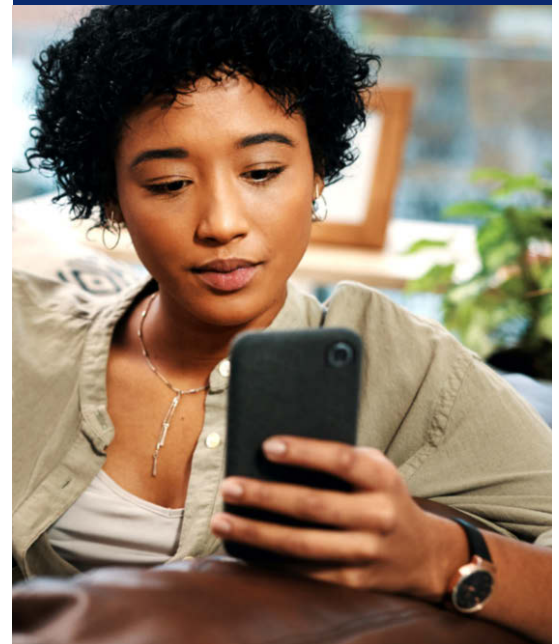
### Save money and time with virtual care

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

▶ Download our Sydney Health mobile app today.



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



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

\*K Health analysis of Q4 2020 visit dispositions.

Sydney Health is offered through an arrangement with CareMarket, Inc., a separate company offering mobile application services on behalf of Anthem Blue Cross and Blue Shield. ©2021-2022.

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## Choose your doctor and see them every time...online.

You can see the same primary care doctor on an ongoing basis through scheduled video visits on your computer or mobile device. Get regular personal health visits and checkups with **LiveHealth Online Virtual Primary Care**. It's like an office visit with a primary care provider (PCP) – without the office. Choose from board-certified, in-network PCPs, and have the same doctor taking care of you over time for treatment including: chronic conditions, preventative care, referrals, acute care.

**With LiveHealth Online Virtual Primary Care you can get:**



Care for diabetes, the flu and other health issues.



Referrals for X-rays, blood work, and specialists.



Prescriptions sent to your local pharmacy.



Appointments  
8 a.m. – 6 p.m. (Mon – Fri).

**We've got you covered. Simplify your life with LiveHealth Online Virtual Primary Care.**



**Virtual primary care visits are available through the Sydney<sup>SM</sup> Health and LiveHealth Online apps, and/or Anthem.com and LiveHealthOnline.com**

Most conditions can be cared for virtually, but there are circumstances that require in-person care. If you need in-person care, or to connect with a specialty doctor, we can help you access the care you need.

Prescription availability is defined by physician judgment and state regulations.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.

# The ins and outs of coverage

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

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

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

## Who can be enrolled

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

- Your spouse
- Your children age 26 or younger, including:
  - A newborn, natural child or a child placed with you for adoption
  - A stepchild
  - Any other child for whom you have legal guardianship

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

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

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

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

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

Renewed	Canceled	When you
●		<ul style="list-style-type: none"> <li>Stay eligible for your employer’s coverage.</li> <li>Pay your share of the monthly payment (premium) for coverage.</li> <li>Don't commit fraud or misrepresent yourself.</li> </ul>
	●	Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.
	●	<ul style="list-style-type: none"> <li>Lose your eligibility for coverage.</li> <li>Don't make required payments or make bad payments.</li> <li>Commit fraud.</li> <li>Are guilty of gross misbehavior.</li> <li>Don't cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries).</li> <li>Let others use your ID card.</li> <li>Use another member's ID card.</li> <li>File false claims with us.</li> </ul> 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 <i>not</i> stipulated in a court decree	The custodial parent's plan is	●	
	The noncustodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

## How benefits apply if you're eligible for Medicare

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

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

## Recovering overpayments

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

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

## What's Not Covered

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

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

t) Neurofeedback / Biofeedback.

- 5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) unless Medically Necessary.
- 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), and physical therapist technicians.
- 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. The exception to this exclusion is outlined in “Balance Billing by Out-of-Network Providers” in the “How Your Plan Works” section.
- 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](http://www.anthem.com).

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

- 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, 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) **Contraceptives** Contraceptive devices including diaphragms, intrauterine devices (IUDs), and implants. (Added when contraceptives are excluded via a qualified religious exemption)
- 16) **Contraceptive Devices** Contraceptive devices including intrauterine devices (IUDs) and implants. (Added when contraceptive devices are excluded via partial religious exemption)
- 17) **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.
- 18) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 19) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
- 20) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 21) **Delivery Charges** Charges for delivery of Prescription Drugs.
- 22) **Dental Devices for Snoring** Oral appliances for snoring.
- 23) **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.
- 24) **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.
- 25) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
- 26) **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.
- 27) **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.
- 28) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
- 29) **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.
- 30) **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.
- 31) **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.

- 32) **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.
- 33) **Eye Exercises** Orthoptics and vision therapy.
- 34) **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.
- 35) **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.
- 36) **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 when the services are medically necessary.
- 37) **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.
- 38) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 39) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
- 40) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If your Group is not required to have Workers' Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 41) **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.
- 42) **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.
- 43) **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.

- 44) **Home Health 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.
- 45) **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.
- 46) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- 47) **Infertility Treatment** Testing or treatment related to infertility. (Replaced with “**Infertility Treatment** Infertility procedures not specified in this Booklet” when Infertility Rider is included)
- 48) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- 49) **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.
- 50) **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.
- 51) **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 Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
  - 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.
  - f) Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.
- 52) **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled “Medicare” in “General Provisions.” If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to [www.medicare.gov](http://www.medicare.gov) for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
- 53) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 54) **Non-approved Drugs** Drugs not approved by the FDA.
- 55) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- 56) **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.
- 57) **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.

- 58) **Off label use** Off label use, unless we must cover it by law or if we approve it.
- 59) **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.
- 60) **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. (Applicable to EPO products only)
- 61) **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) Hypoallergenic 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.
- 62) **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 Health Care Services” benefit.
- 63) **Prosthetics** Prosthetics for sports or cosmetic purposes.
- 64) **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.
- 65) **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.
- 66) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.
- 67) **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 Anthem. (Applicable to EPO products only)
- 68) **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. (Applicable to EPO products only)
- 69) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 70) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 71) **Sterilization** Services to reverse elective sterilization. (Replaced with “**Sterilization** For female sterilization or reversal of sterilization.” When there is a qualified religious exemption)
- 72) **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).
- 73) **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 74) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 75) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 76) **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.
- 77) **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.
- 78) **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.

- 79) **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. (Replaced with “**Weight Loss Services and Surgery** Except for Covered Services for the treatment of morbid obesity described in the Bariatric Surgery Rider, your coverage does not include benefits for services and supplies related to obesity or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem.” when Bariatric Surgery Rider is included)
- 80) **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. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at [www.anthem.com](http://www.anthem.com).

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

5. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA approved, 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.
6. **Contraceptives** Contraceptive Drugs, injectable contraceptive Drugs and patches unless we must cover them by law. (Added when contraceptives are excluded via a qualified religious exemption)
7. **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.
8. **Delivery Charges** Charges for delivery of Prescription Drugs.
9. **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.

10. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at [www.anthem.com](http://www.anthem.com). If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.
11. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
12. **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.
13. **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.
14. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the “What’s Covered” section.  

This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
15. **Emergency Contraceptives** Emergency contraceptives (also referred to as “the morning-after pill”), such as Plan B and Ella. (Added when contraceptive devices are excluded via partial religious exemption)
16. **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.
17. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider’s failure to submit medical records required to determine the appropriateness of a claim.
18. **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.
19. **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.
20. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
21. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT). (Removed when Infertility Rider is included)
22. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment (DME), Medical Devices and Supplies” benefit. Please see that section for details.
23. **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.

24. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
25. **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.
26. **Non-approved Drugs** Drugs not approved by the FDA.
27. **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.
28. **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.
29. **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.
30. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
31. **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.
32. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
33. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
34. **Weight Loss Drugs** Any Drug mainly used for weight loss.



# We're here for you – in many languages

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

## Spanish

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

## Chinese

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

## Vietnamese

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

## Korean

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

## Tagalog

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

## Russian

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

## Armenian

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

## Farsi

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

## French

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

## Arabic

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

## Japanese

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

## Haitian

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

## Italian

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

## Polish

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

## Punjabi

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

## TTY/TTD:711

## It's important we treat you fairly

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



# Protecting your privacy

## How we keep your information safe and secure

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

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

### How we help manage your care

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

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

### Special enrollment rights

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

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

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

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For full details, read your plan document, which has all the details about your plan. You can find on [anthem.com](https://www.anthem.com).





## Your plan is here for you to use

### If you would like extra help

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



Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2023 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

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