DIETITIANS ON DEMAND

Anthem KeyCare 2500

Medical Plan Overview

Choosing and using your plan

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

Your Anthem Benefits

Dietitians on Demand

Effective January 1, 2024

Anthem

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Time to review 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.

Understanding your benefits

When choosing your plan, think of the four "C"s:

1. **Consider** your personal situation. If things have changed since last year, you may want to look for benefits that fit those needs.

- Have your healthcare needs changed?
- Do you go to the doctor more often now?
- Is a special prescription drug needed?
- Are you expecting a baby?

2. **Compare** all the costs:

- Monthly payment
- Deductible
- Coinsurance
- Copay
- Out-of-pocket limit

3. **Check** to see if your doctors, hospitals, and other healthcare professionals are covered by the plan.

4. **Choose** the right plan for your needs.

Common healthcare terms

Coinsurance:

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

Copay:*

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

Deductible:

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

Out-of-pocket limit:

This is the maximum amount you could pay before your plan starts to pay 100% of all covered healthcare costs.* It's the sum of the deductible and coinsurance amounts.

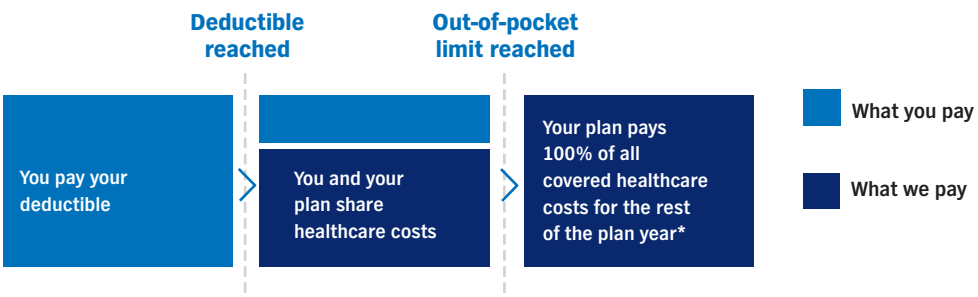
Premium:

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

Glossary of terms:

Visit **anthem.com/glossary**

What you pay and what your plan says



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

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

Explore your plan

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

PPO

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

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

Using your plan

How to use your plan

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 healthwith 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.

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

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.[1] 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.[2]

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.
- Call 24/7 NurseLine and receive helpful advice from a registered nurse.

1 Blue Cross Blue Shield Association, Personalized Healthcare, Nationwide (accessed March 2023): bcbs.com.

2 GeoBlue, More than 20 years as a leader in international healthcare (accessed March 2023): about.geo-blue.com.

3 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.

Plan extras that support your health

Medical guidance

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

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

Building Healthy Families — This program offers support to help your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through our **Sydney Health** app and features an extensive content library covering topics to support diverse families, including single parents, same-sex, or multicultural couples. In addition, the app features many tools, including fertility, diaper change, and feeding trackers, due date calculators, and blood pressure monitoring. Visit the **Sydney Health** app to enroll today.

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

ConditionCare — Receive support from a dedicated nurse team to manage ongoing conditions, such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, or heart failure. Work with dietitians, health educators, and pharmacists who can help you learn about your condition and manage your health. Call **866-962-1071** to begin.

Healthy living

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

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

Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: AEYE

Your Plan: Anthem KeyCare 30 2500/20%/6500 Rx $15/$50/$85/20%

Your Network: KeyCare

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$2,500 person / $5,000 family	$5,000 person / $10,000 family
Overall Out-of-Pocket Limit	$6,500 person / $13,000 family	$16,250 person / $32,500 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. 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).*		
Preferred PCP *virtual and office*	$20 copay per visit medical deductible does not apply	Not covered
Primary Care (PCP) *virtual and office*	$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
Mental Health and Substance Use Disorder Services *virtual and office*	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per benefit period.*	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Other Services in an Office		
Allergy Testing	$20 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	No charge	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preferred Reference Lab	No charge	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
X-Ray		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Emergency Room Facility Services	20% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	20% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery **Facility Fees**		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Ambulatory Surgical Center	$350 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 30 visits combined per benefit period. Coverage for speech therapy is limited to 30 visits per benefit period.*		
Office	$30 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Inpatient Hospice	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Durable Medical Equipment	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

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

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Retail 90 Pharmacy *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *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.*		
Tier 1 - Typically Generic	$15 copay per prescription (retail) and $30 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand	$50 copay per prescription (retail) and $125 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$85 copay per prescription (retail) and $213 copay per prescription (home delivery)	40% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $300 per prescription (retail and home delivery)	40% coinsurance (retail) and Not covered (home delivery)

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

Notes:

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

- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- The representations of benefits in this document are subject to Virginia Bureau of Insurance (BOI) approval and are subject to change.

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

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

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

You can take your benefits with you

with the BlueCard® PPO and Blue Cross Blue Shield Global® Core programs

If you are away from home and you need care right away, you're covered. As an Anthem Blue Cross and Blue Shield (Anthem) member, you have access to care across the country through the **BlueCard® PPO Program**. This includes **95% of doctors and 96% of hospitals in the U.S.**[1]

To access care across the U.S., you can:

Call 911 or **go to the nearest hospital** in an **emergency**.*

Go to anthem.com, log in and use the **Find a Doctor** tool to search for a BlueCard PPO Program doctor or hospital.

Use the Sydney Health mobile app to search for a BlueCard PPO Program doctor or hospital. You can receive turn-by-turn directions to the nearest doctor, urgent care center or hospital.

Call Member Services at the number on your ID card. They can help you find a doctor or hospital.

*You or a family member needs to call the Member Services number on your ID card within 24 hours (48 hours for members in Indiana) after going to the hospital or as soon as you can.

General tips for traveling

Here is what you need to know:

- Ask Member Services if your international benefits are different before leaving the country.
- Call Member Services to understand if you need to be preapproved for any type of care. The number is on you ID card.
- Save money by seeing a BlueCard program doctor or hospital. You only pay your usual out-of-pocket amounts (such as a deductible, your percentage of costs or copay). If you go to a doctor or hospital outside the program, you will need to pay the entire bill up front.
- Show your Anthem ID card so the doctor or hospital can check your benefits and send us a claim for processing.

Your member ID card is always with you

PPO®

The "PPO-in-a-suitcase" symbol shows you can receive care from BlueCard PPO Program doctors and hospitals. You can also carry a digital ID card wherever you go. Find it by logging on to anthem.com or the Sydney Health mobile app.

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Access care around the world

Use the **Blue Cross Blue Shield Global® Core Program**. It gives you access to preferred doctors and hospitals in 190 countries and territories around the world.[2]

To access care outside the U.S.:

Go straight to the nearest hospital in an emergency.

Go to bcbsglobalcore.com to search for a doctor or hospital.

Use the Blue Cross Blue Shield Global Core app to find a doctor or hospital.

Call the Blue Cross Blue Shield Global Core Service Center 24/7 at **1-800-810-2583 (BLUE)** or call collect at **1-804-673-1177**. They can help you set up a doctor visit or hospital stay.

Before you access care outside of the U.S.

Unless it's an emergency, please call the Global Core Service Center before accessing care outside the U.S. Global Core will work with the doctor and Anthem to approve and accept a Guarantee of Payment (GOP). If you receive care from a doctor or hospital that has not accepted a GOP:

1. You will need to pay up front in full for your care.
2. Download an international claim form at **bcbsglobalcore.com** or call Member Services at the number on your ID card for help.
3. Fill out the claim form and send it with the original bills to the Blue Cross Blue Shield Global Core Service Center. You can submit claims through the mobile app, email or postal mail.

Your health benefits are your travel companion. They go where you go, so you will never have to worry about coverage when you're away from home.

You can download the Blue Cross Blue Shield Global Core app today

With the app, you can:

- Search for a doctor or hospital.
- Submit claims.
- Find help with medical terms and phrases for many symptoms translated — and even use an audio feature to play the translation.
- Find a drug's generic name, local brand name and check whether it's available.
- Receive information about how to find and contact a U.S. embassy.

Download on the App Store | ANDROID APP ON Google play

1 Blue Cross Blue Shield Association website, *The Blue Cross Blue Shield System* (accessed February 2020): bcbs.com/about-us/the-blue-cross-blue-shield-system.
2 GeoBlue® website, *More than 20 years as a leader in international healthcare* (accessed February 2020): about.geo-blue.com.The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

Stay on top of your health

Use your preventive care benefits

Regular preventive care can help you stay healthy and catch problems early, when they are easier to treat. Our health plans offer all the preventive care services and immunizations below at no cost to you.[1] 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 make sense for you, talk to your doctor.

Preventive care vs. diagnostic care

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

Adult preventive care

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

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- 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, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)[2, 3]
- Depression screening
- Diabetes screening (type 2)[4]
- Eye chart test for vision[5]
- Hepatitis B virus (HBV) screening for people at increased risk of infection
- Hearing screening
- Height, weight, and body mass index (BMI) measurements
- Hepatitis C virus (HCV) screening
- Human immunodeficiency virus (HIV): screening and counseling
- Interpersonal and domestic violence: screening and counseling
- Lung cancer screening for those ages 50 to 80 who have a history of smoking 20 packs or more per year and still smoke, or who have quit within the past 15 years[2]
- Obesity: related screening and counseling[4]
- Prostate cancer screenings, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening

Women's preventive care:[6]

- Breast cancer screenings, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met[7]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling[8, 9]
- 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[9]
- Interpersonal and domestic violence: screening and counseling
- Pelvic exam and Pap test, including screening for cervical cancer
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV, and depression[9]
- 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)
- 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.

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Child preventive care

Preventive physical exams, screenings, and tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure screening
- Cervical dysplasia screening
- Cholesterol and lipid (fat) levels screening
- Depression screening
- Development and behavior screening
- Diabetes screening (type 2)
- Hearing screening
- Height, weight, and BMI measurements
- Hemoglobin or hematocrit (blood count) screening
- Lead testing
- Newborn screening
- Obesity: related screening and counseling
- 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
- Tobacco use: related screening and behavioral counseling
- Vision screening, when done as part of a preventive care visit[5]

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type B (HIB)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- 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, even for OTC items.

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

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease (CVD), preeclampsia, and colorectal cancer in adults younger than age 70
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening for individuals ages 45 to 75
- Generic low-to-moderate dose statins for individuals ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Metformin (850 mg) to prevent or delay progression of diabetes in individuals ages 35 to 70
- Preexposure prophylaxis (PrEP) for the prevention of HIV
- Tobacco cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for individuals 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

Women's preventive drugs and other pharmacy items (age appropriate):[6]

- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria[2]
- Contraceptives, including generic prescription drugs, brand name drugs with no generic equivalent, and OTC items like condoms and spermicides[9,11]
- 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

If you'd like more help understanding your preventive care benefits, call the number on the back of your member 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.

1 The range of preventive care services covered at 100% when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by Health Resources and Services Administration (HRSA) guidelines.You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

2 You may be required to receive preapproval for these services.

3 The follow-up colonoscopy after a positive stool-based or direct visualization (such as a CT colonography or flexible sigmoidoscopy) colorectal cancer screening is considered a screening colonoscopy, meaning it is paid at 100% (so you pay no share of the cost) when provided by a doctor in the plan's network.

4 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.

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

6 Keep in mind, these recommendations are categorized by "men" and "women," and are driven by biological sex (male and female) rather than gender identity. Meet with your doctor to determine which recommendations best apply to you based on individual factors, such as your sex assigned at birth and current anatomy.

7 Check your medical policy for details.

8 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.

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

10 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 share of the cost (deductible, copay, or coinsurance) for you. Contact the provider to see if such services are available.

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

Save money
with SpecialOffers and discounts

As part of your health plan, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through SpecialOffers, which can help you save money while taking care of your health.

Dental, hearing, and vision

Dental

RefreshaDent

Save on premium dentures sent direct to your home. You can receive a 50% discount on a lifetime warranty. This program includes a lifetime digital record of your dentures for easy replacement.

Hearing

NationsHearing®

Receive hearing screenings and in-home service at no additional cost. You can also receive hearing aids at a discounted rate.

Hearing Care Solutions

Receive no-cost hearing exams and discounts on hearing aids. Hearing Care Solutions has 3,100 locations and eight manufacturers, and offers a three-year warranty, batteries for two years, and unlimited visits for one year.

Amplifon

Save on top-quality care and ongoing service and support for your hearing aids.

Eyewear

Glasses.com® and 1-800 CONTACTS®

Shop for the latest brand-name frames at a fraction of the cost for similar frames from other retailers. You can also receive additional savings on orders of $100 or more, plus no-cost shipping and returns.

EyeMed

Take advantage of discounts on new glasses, nonprescription sunglasses, and eyewear accessories.

LASIK

Premier LASIK Network

Save on LASIK when you choose any featured Premier LASIK Network provider.

TruVision

Save on LASIK eye surgery at over 1,000 locations.

Health and fitness

Health

BREVENA

Enjoy a discount on BREVENA skin care creams and balms for smooth, rejuvenated skin from head to toe.

ChooseHealthy®

Discounts are available on acupuncture, chiropractic, massage, podiatry, physical therapy, and nutritional services. You also have discounts on fitness equipment, wearable health trackers, and health products such as vitamins and nutrition bars.

LifeMart®

Receive deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services, yoga classes, sports gear, and vision care.

Fitness

Active&Fit Direct™

Choose from more than 11,900 participating fitness centers nationwide at a discounted rate. This program is offered through American Specialty Health Fitness, Inc.

Fitbit®

Work toward your fitness goals with Fitbit trackers and smartwatches that fit your lifestyle and budget.

Garmin®

Discounts are available on select Garmin wellness devices.

Husk Wellness

Discounts are available for gym memberships, fitness equipment and technology, and fitness and nutrition coaching.

Family and home

Family

23andMe®

Save on health and ancestry kits to learn about your wellness, ancestry, and more.

WINFertility®

Save up to 40% on infertility treatment. WINFertility helps make quality treatment more affordable.

Home

Nationwide® pet insurance

Receive discounts when you enroll through your company or organization. Additional savings are available when you enroll multiple pets.

ASPCA® Pet Health Insurance

Find reduced rates on pet insurance and choose from three levels of care, including flexible deductibles and custom reimbursements.

Medicine and treatment

Medicine

Puritan's Pride®

Choose from a large selection of discounted vitamins, minerals, and supplements.

Allergy Control Products and National Allergy Supply™

Save on select doctor-recommended products such as allergy-friendly bedding, air purifiers and filters, and asthma products. Some orders qualify for no-cost ground shipping within the contiguous U.S.

Treatment

The Living Well Course Series

Choose one of the online wellness programs and save on coaching to help you lose weight, stop smoking, manage stress or diabetes, restore sound sleep, or address alcohol or substance dependence.

Learn more about SpecialOffers
Log in to anthem.com, choose **Care**, and select **Discounts.**

Wellbeing Solutions

can help you achieve better health

Your whole health matters. That's why your plan includes Wellbeing Solutions programs to help you with everyday health and your well-being.

It's easy to participate in Wellbeing Solutions programs using Sydney℠ Health, our fully integrated mobile app, and **anthem.com**. You can access these resources anytime to find Wellbeing Solutions programs that match your healthcare needs.

Connect with Sydney Health

Use Sydney Health for a convenient way to find information about your medical, pharmacy, dental, vision, and Wellbeing Solutions benefits.

1. Download the Sydney Health mobile app by scanning this QR code with your smartphone, or visit **anthem.com**
2. Register and log in.
3. Go to *MyHealthDashboard*, your hub for personalized health and wellness.

Available on the App Store

GET IT ON Google Play

Anthem

Explore your plan's powerful benefits

Here are the Wellbeing Solutions programs you can explore at Sydney Health > My Health Dashboard > Programs

Managing your everyday health:

24/7 NurseLine

Talk to a registered nurse at any time to receive answers or advice on any immediate care questions for you or your family. A nurse can also connect you to other well-being programs that are part of your plan.

Behavioral Health Case Management

If you're trying to manage a behavioral health condition, you don't have to do it alone. Our behavioral health case managers are licensed mental health professionals. They provide strong support and guidance for you and your family to help improve your quality of life.

Case Management

After an illness or hospitalization, you can receive personalized support and care coordination from a team of medical professionals. They will guide you when you have to make decisions about your care, set up appointments, understand costs, and go through the healing process.

Emotional Well-being Resources

You have the support you need to develop resilience, reduce stress, and practice mindfulness. Digital tools help you identify thoughts and behavior patterns that affect your emotional well-being. Through online programs and personalized coaching, you'll learn effective ways to manage stress, anxiety, depression, substance use, and sleep issues.

Health Assessment

Complete your health assessment to receive your personalized report. Know what's going well and if there are any at-risk areas you need to work on to improve your health.

MyHealth Advantage

We provide you with a confidential health summary that includes money-saving tips, prescription drug updates, reminders for checkups, tests, and exams, lists of claims and prescriptions, and general health tips. Choose **Suggestions** in the *Secure Message Center* on Sydney Health or **anthem.com**

Managing specific conditions:

Autism Spectrum Disorder Program

Receive support for a covered family member with an autism spectrum disorder. A licensed behavior analyst can help you navigate the healthcare system and address any unique family challenges. We focus on the whole family and work with all of you to understand and access available care.

ConditionCare

Receive one-on-one support from a healthcare professional for a chronic condition, like asthma or diabetes, to help you reach your health goals. We may call you to find out if ConditionCare would be a good fit for your needs.

Future Moms

If you're having a baby, Future Moms can help you have a healthier pregnancy and a smooth delivery. We're here to support you in caring for your new baby so you can have the best possible start together.

We're glad to support you

With Wellbeing Solutions, you can continue on your path to whole-person health knowing you have the care and support to help you with each step. If you have any questions, call the Member Services number on your ID card.

Wellbeing Solutions

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

The more activities you complete, the greater your reward

The Wellbeing Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below sponsored by your employer, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $200.

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam[2]	$25
	Get an annual flu shot	$20

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Activity Type	Activities	Amount
Condition management programs	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[3]	Up to $50 ($20/$30)
	Building Healthy Families: Support is available through the Sydney℠ Health app wherever you are in your family planning process, such as trying to conceive or raising your toddler[4]	Up to $40 ($10/$10/$10/$10)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[5]	$25
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[6]	$25
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$10

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app offers you 24/7 personalized support. Well-being Coach can help you maintain a healthy weight, quit tobacco, and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, talk to a certified health coach.

Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

Preventive care: Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.

Condition management: Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include: ConditionCare (for asthma, diabetes, and heart or lung conditions), Building Healthy Families, and Well-being Coach for weight management and tobacco cessation.

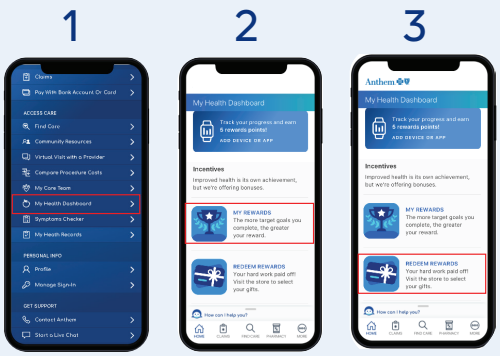
Digital and wellness activities: Log in to the Sydney Health app or **anthem.com** to complete available activities, such as taking a health assessment, participating in the Well-being Coach digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Use your rewards toward electronic gift cards for select retailers.

1 To view your rewards, open the Sydney Health app or go to **anthem.com**. Next, go to *My Health Dashboard*.

2 Select **My Rewards**.

3 Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap Options (all brands), Apple, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.



Download the Sydney Health mobile app by scanning this QR code with your phone's camera.

Do you have questions?

Log in at **anthem.com** or open the Sydney Health app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call Member Services at the number on your ID card.

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

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

3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: (chronic obstructive pulmonary disease [COPD], coronary artery disease [CAD], asthma, diabetes, and congestive heart failure [CHF]. Rewards include: $20 for program participation and $30 for program completion.

4 Building Healthy Families milestone completion dates: BHF Pregnancy Screener must be completed in first trimester; at least 1 of 6 mini assessments must be completed by one day prior to delivery; postpartum assessment must be completed by 56 days after delivery. Rewards include: $10 for profile completion; $10 for a BHF Pregnancy Screener; $10 for completing at least 1 of 6 mini assessments; $10 for a postpartum assessment.

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

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

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

We encourage you to actively participate in your rewards program. Rewards earned should be redeemed before the end of the current plan year. Unused rewards are forfeited three months after the end of your plan year. Make sure to redeem them before then.

All preventive care activities are claims-based, which means your completion is determined when a claim is processed. Medical waivers apply to claim-based activities.

Rewards eligibility applies only to subscribers and their enrolled spouse/domestic partner. Members must be active on the plan and their activity must take place during the plan year. A subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.

The reward amount you receive may be considered income to you and subject to state and federal taxes in the tax year it is paid. You should consult a tax expert with any questions regarding tax obligations.

Electronic gift card availability may vary. The list of retailers available for electronic gift card rewards redemption is subject to change. Log on to anthem.com or open the Sydney Health app to explore the electronic gift card options available to you.

Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ 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 **anthem.com/es**.

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 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 Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

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Anthem

Receive virtual care and support 24/7 with our Sydney Health app

Now you can connect more easily to the care you need through our **Sydney℠ Health** mobile app. Have a video visit with a doctor on your mobile device or computer with a camera, 24/7.

Visit with a doctor for common health concerns

Doctors are available anytime, with no appointments or long wait times. They can help you with these types of conditions:

- COVID-19
- Flu
- Cold and fever
- Minor rashes
- Sore throat
- Headaches

During your video visit, the doctor will assess your condition, provide a treatment plan, and send prescriptions to the pharmacy of your choice, if needed.[1]

What people say about virtual care visits[2]

89%
said the doctor they saw was professional and helpful

92%
thought the doctor understood their concerns

92%
were able to book a virtual visit sooner than an in-person visit

How to download our Sydney Health app:

sydney

Download on the App Store

GET IT ON Google Play

Scan the QR code with your phone's camera.

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Here's how to access the program through virtual care:

Download our no-cost **Sydney Health** app.

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for our app and **anthem.com.**
3. Select **Care** and then select **Video Visits.**

Visit **anthem.com.**

1. Register (if you haven't yet) and log in.
2. Once you register, your username and password are the same for **anthem.com** and our **Sydney Health** app.
3. Select **Care** and then select **Virtual Video Visit With A Provider.**

1 Prescription availability is defined by physician judgment.

2 Based on Sydney Health utilization trends from top national clients.

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.

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

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.

Anthem®
And Its Affiliate HealthKeepers, Inc.

A closer look at 2023 pharmacy benefits

Because pharmacy is the most-utilized healthcare benefit, we are adding pharmacy products and programs in 2023 to help you manage costs, provide flexibility, and maintain a positive healthcare experience for your employees.

Important name change

Starting in January 2023, **IngenioRx** will become **CarelonRx**. This will not impact your benefits, coverage, or how your employees fill prescriptions. IngenioRx Home Delivery will also change to CarelonRx Mail, and IngenioRx Specialty Pharmacy will change to CarelonRx Specialty Pharmacy.

Advantage Retail Pharmacy Network

Nearly 57,000 pharmacies are included in the Advantage Network.* This network also uses ZipDrug, which delivers personalized pharmacy care by matching people who take maintenance medications with local preferred pharmacies with the highest adherence scores, free hand delivery, and other optional services for managing medications.

This network does not include Walgreens, Walgreens-owned pharmacies, Duane Reade, or some independent pharmacies. To find a pharmacy in the Advantage Network, your employees can:

- Log in at **anthem.com** and select **Find a Pharmacy**. They also can use the Sydney℠ Health app to find a pharmacy or switch to home delivery.
- Call the Member Services number on their ID card.
- View a network directory by visiting **anthem.com/pharmacyinformation** and selecting **Rx Networks**.

Retail 90

Your employees can make fewer trips to the pharmacy by receiving a 90-day supply of a covered medication at participating Retail 90 pharmacies. All they have to do is pay three times their 30-day cost share for prescriptions. Over 99% of pharmacies in the Advantage Network participate in Retail 90.*

Essential Drug List

The Essential Drug List helps ensure there are no gaps in care by using a closed formulary that excludes drugs with over-the-counter (OTC) or lower-cost formulary options. That means your employees have access to medications they need while keeping healthcare costs down.

We are here to help

If you have any questions, please contact your Anthem representative.

* IngenioRx internal data, 2022.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022

IngenioRx, Inc. is a separate company providing utilization review services on behalf of your health plan.

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ACA Preventive Care
Drug List

Anthem

Preventive care can help keep you healthy and may even save your life. Getting routine health exams and screenings can help catch problems early, when they're easier to treat. And getting the right preventive care services can help you manage your health conditions and stay healthy.

Under the Affordable Care Act (ACA), pharmacy benefits must cover certain categories of preventive care drugs and products at 100%. That means you don't have to pay a share of the cost — no copay, deductible or percentage of the cost (coinsurance).

How do I get these drugs at no cost?
Talk with your doctor about choosing the medication or product that's right for you. To get these preventive drugs, including over-the-counter (OTC) drugs or products:

- They must be right for your age and condition.
- You'll need to get a prescription from your doctor (even for OTC products).
- Remember, only you and your doctor can decide on the medications you need and what's best for your health.

Preventive drugs and products, by category
Here's a list of medications Carelon plans will cover with no cost-share for you under the ACA. Keep in mind that this list can change. Brand-name drugs are listed with a first capital letter. Non-brand drugs (generics) are in lowercase letters.

ASPIRIN

Coverage includes generic over-the-counter 81mg aspirin products to prevent preeclampsia in pregnant women.

Aspirin 81mg (tab, ec tab, chew)

BOWEL PREP

Coverage includes generic prescription and over-the-counter products and are limited to two (2) bowel prep kits per year for adults 45 - 75 years old.

bisacodyl
bisacodyl-peg 3350-pot chloride-sod bicarb-sod chloride
magnesium citrate, hydroxide
peg 3350-potassium chloride-sod bicarbonate-sod chloride (generic Nulytely)
peg 3350-kcl-sod bicarb-sod chloride-sod sulfate (generic Golytely)
peg 3350-kcl-nacl-na sulfate-na ascorbate-ascorbic acid (generic Moviprep)
polyethylene glycol 3350
na sulfate-k sulfate-mg sulf (generic Suprep)

BREAST CANCER

You may be required to get preapproval for the services associated with the drugs in this category. If there is a previous diagnosis of breast cancer, the applicable cost share will apply

anastrozole 1mg
exemestane 25mg
letrozole 2.5 mg
raloxifene 60mg
Soltamox
tamoxifen 10mg, 20mg

CARDIOVASULAR

Full coverage for low-to-moderate dose generic statins will be limited to members 40-75 years old with one or more cardiovascular risk factor such as dyslipidemia, diabetes, hypertension, or smoking but who have not experienced a cardiovascular disease event.

atorvastatin (10 - 20 mg)
fluvastatin (20 - 80 mg)
lovastatin (10 - 40mg)
pravastatin (10 - 80mg)
rosuvastatin (5 - 10mg)
simvastatin (5 - 40mg)

CONTRACEPTION

This benefit also applies to those younger than age 19. A cost share may apply for other prescription contraceptives, based on your drug benefits. If the contraceptive you are taking is not on the formulary, your doctor can contact us if it is medically necessary because the preferred contraceptives are inappropriate for you, and we will waive your cost share.

Oral Contraceptives
afirmelle 0.1-0.02
altavera
alyacen 7/7/7
amethia
amethia lo
amethyst 90-20mcg
apri
aranelle
ashlyna
aubra 0.1-0.02
aubra eq 0.1-0.02
aurovela 1.5/30
aurovela 1/20
aurovela 24 fe 1/20
aurovela fe 1.5/30
aurovela fe 1/20
aviane
ayuna
azurette 28
balziva
bekyree
blisovi 24 fe 1/20
blisovi fe 1.5/30
blisovi fe 1/20
briellyn
camila 0.35mg
camrese
camrese lo
caziant
chateal 0.15/30
chateal eq 0.15/30
cryselle-28
cyclafem 1/35
cyclafem 7/7/7
cyred
cyred eq
dasetta 1/35
dasetta 7/7/7
daysee
deblitane 0.35mg
delyla 0.1-0.02
deso/ethinyl estradio
dros/eth est levomefo
drospir/ethi 3-0.03mg
drospire/eth/estr/lev
drospirenone ethy est
elinest
emoquette
enpresse-28
enskyce
errin 0.35mg
estarylla 0.25-35
ethy eth est 1-35
ethynodiol 1-50
falmina
fayosim
femynor 0.25-35
gemmily 1/20
gianvi 3-0.02mg
hailey 1.5/30
hailey 24 fe
heather 0.35mg
incassia 0.35mg
introvale
isibloom
isibloom 0.15-30
jaimiess
jasmiel 3-0.02mg
jencycla 0.35mg
jolessa
jolivette 0.35mg
juleber
junel 1.5/30
junel 1/20
junel fe 1.5/30

junel fe 1/20
junel fe 24 1/20
kaitlib fe
kalliga
kariva 28
kelnor 1/35
kelnor 1/50
kimidess
kurvelo 0.15/30
larin 1.5/30
larin 1/20
larin 24 fe 1/20
larin fe 1.5/30
larin fe 1/20
larissia
layolis fe
leena
lessina
levo-eth est 90-20mcg
levonest
levonor/ethi
levonor/ethi 0.1-0.02
levonor/ethi estradio
levora-28 0.15/30
lillow 0.15/30
lojaimiess
loryna 3-0.02mg
low-ogestrel
lo-zumandimi 3-0.02mg
lutera
lyza 0.35mg
marlissa 0.15/30
melodetta 24 fe
merzee 1/20
mibelas 24 fe
microgestin 1.5/30
microgestin 1/20
microgestin fe 1/20
microgestin fe1.5/30
mili 0.25/35
mircette 28 day
mono-linyah 0.25-35
mononessa
myzilra
necon 0.5/35
necon 7/7/7
nikki 3-0.02mg
nor/est/ff 1.5/30
nora-be 0.35mg
nore/eth/fer 0.4mg-35
noreth/ethin fe
noreth/ethin fe 1/20
noreth/ethin 1.5/30
noreth/ethin 1/20
noreth/ethin fe 1/20
nore/eth/fer 1/20
norethindron 0.35mg
norgest/ethi 0.25/35
norgest/ethi/estradio
norlyroc 0.35mg
nortrel 0.5/35
nortrel 1/35
nortrel 7/7/7
ocella 3-0.03mg
ogestrel
orsythia
philith 0.4-35
pimtrea
pirmella 1/35
pirmella 7/7/7
portia-28
previfem
quasense
rajani
reclipsen
rivelsa
setlakin
sharobel 0.35mg
simliya 28
simpesse
sprintec 28
sronyx
syeda 3-0.03mg
tarina 24 fe
tarina fe 1/20
tarina fe 1/20 eq
taysofy 1/20
tilia fe
tri femynor
tri-estaryll
tri-legest fe
tri-linyah
tri-lo estaryll
tri-lo marzia
tri-lo- sprintec
tri-lo-mili
tri-mili
trinessa
trinessa lo
tri-previfem
tri-sprintec
trivora-28
tri-vylibra
tri-vylibra lo
tulana 0.35mg
tydemy
velivet
vestura 3-0.02mg
vienva 0.1-20
viorele
volnea
vyfemla 0.4-35
vylibra 0.25-35
wera 0.5/35
wymzya fe chw 0.4mg-35
zarah 3-0.03mg
zenchent
zovia 1/35e
zumandimine 3-0.03mg

Cervical Caps (Rx)
Femcap mis 22-30mm

Diaphragms
Caya dpr
Omniflex
Wide-seal dpr kit 60-95

Emergency Contraception (Rx or OTC)
aftera tab 1.5mg
econtra ez tab 1.5mg
Ella tab 30mg
levonorgestr tab 1.5mg
my choice tab 1.5mg
my way tab 1.5mg
new day tab 1.5mg
next choice tab 1.5mg
opcicon 1.5mg
preventeza tab 1.5mg
react tab 1.5mg
take action tab 1.5mg

Condoms (OTC)
female condoms
male condoms

Injectables (Rx)
depo-sq prov inj
medroxypr ac inj 150mg/ml

Intrauterine Devices and Vaginal Rings
eluryng mis
etonogestere mis ethy est

Spermicides (OTC)
conceptrol gel 4%
encare sup 100mg
gynol ii gel 3%
Shur-Seal gel 2%
VCF vaginal aer gel,mis contracp

Transdermal
xulane dis 150-35

Vaginal Sponge
Today sponge mis

FLUORIDE (GENERIC ONLY)

Coverage for children age 6 months to 16 years.

sodium fluoride chew 0.25mg, 0.5mg, 1mg, 2.2mg
sodium fluoride tab 0.5mg, 1mg
sodium fluoride soln 0.25mg 0.5mg 0.125mg
pediatric multivitamin/ fluoride chew, tab, soln 0.25mg, 0.5mg, 1mg,0.125mg, 1.1mg, 2.2mg

FOLIC ACID

Coverage for generic only, prescription and over-the-counter included for women ages 55 or younger who are planning and able to get pregnant.

folic acid tab,cap 400mcg, 800mcg
Prenatal and multivitamins w/ folic acid (generic OTC only)

HIV PRE-EXPOSURE PROPHYLAXIS

emtricitabine 200mg tenofovir 300mg
emtricitabine-tenofovir 200-300mg

PREDIABETES

Full coverage of metformin 850mg is limited to members 35-70 years old who have prediabetes.

metformin 850mg

SMOKING CESSATION

Coverage includes prescription and over-the-counter, brand and generic for members greater than 18 years old.

OTC (Brand and Generic)
Nicotine Replacement Gum, Lozenge and Patch
(Prescription)
Chantix Tablet
Nicotrol Inhaler
Nicotrol Nasal Spray
varenicline

VACCINES

BCG
COVID-19
Diphtheria, Tetanus, Pertussis
Haemophilus B Polysac Conj
Hepatitis A
Hepatitis B
Human Papillomavirus (HPV)
Influenza Virus
Measles, Mumps & Rubella Virus
Meningococcal
Monkeypox
Pneumococcal
Poliovirus, IPV
Rotavirus , Oral
Respiratory Syncytial Virus (RSV)
Varicella Virus
Zoster (shingles)

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.

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The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

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

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

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

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

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

Special enrollment periods

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

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

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

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

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

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

Factors used to set the price of health care coverage for employers with 51-99 employees:

- The plan selected by your employer
- Your employer's location
- The age and gender of each employee
- The number of enrolled employees
- The number of dependents enrolled by each enrollee
- The health status of the enrolled employees and their dependents
- Your employer's industry

When you're covered by more than one plan

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

Determining the primary and secondary plans

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

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

How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

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

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

What's Not Covered

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

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) Bioenergial 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.

    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 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.

   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. 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.

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**. For a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

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

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

Special enrollment rights

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

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

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**.

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

Have any questions about your plan?

Your benefits administrator or human resources representative will contact you soon with specific enrollment instructions for your organization.

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.

Anthem

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