



*Ready to choose your benefits?*  
**We can point you in the right direction.**

City of Salem & Salem City Schools  
Choose from 3 medical plans  
Effective October 1, 2016



And Its Affiliate HealthKeepers, Inc.

## **An Anthem Blue Cross and Blue Shield ID card means something**

It means you have access to quality care from quality doctors. It means you can always get your questions answered. It means you have our support before you ever need health care. And that's what this guide is for. We want you to have everything you need to make a good decision.



You can register at [anthem.com](https://www.anthem.com) or on the mobile app — your simple and convenient solution to managing your health.

## Frequently asked questions (FAQ)

### Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your benefits if you choose a doctor in your plan. Some plans cover only services from doctors in your plan, which means you pay for the full cost if you see a doctor outside of the plan. Other plans cover services from doctors outside the plan — but your plan pays more of the cost when you see a doctor in your plan. Be sure to check the details of your plan.

To find out if your doctor is in the plan, or to find a new doctor in the plan, go to our *Find a Doctor* tool on [anthem.com](https://www.anthem.com). You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the doctors that serve your plan. You can also use *Find a Doctor* on your smartphone.

### What prescription drugs are covered?

View the drugs we cover at [www.anthem.com/VA/Nationaltier4](https://www.anthem.com/VA/Nationaltier4).

And here's a tip: you'll often pay less for generic versions of higher-cost name brand drugs.

If you are sick or have a condition, you may need “specialty” drugs. Your benefits includes these types of drugs and the support you may need when you take them.

To learn more about helpful RX programs, check out the Customer Support section on [anthem.com](https://www.anthem.com). Then go to [FAQ>Pharmacy](#).

### How do I use my health plan when I need care?

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor. You can also show a copy of your ID card from the Anthem mobile app.

### Is preventive care covered?

Yes, preventive care from a doctor in the plan is covered at 100%. It's very important to take care of your health with regular checkups even when you feel fine. So talk to your doctor about screenings and immunizations that you may need to protect your health.

### Can I manage my plan and health care on [anthem.com](https://www.anthem.com)?

Yes. As soon as you become a member, you'll be able to register at [anthem.com](https://www.anthem.com) or on the Anthem mobile app. It's designed to help you manage your health care and your benefits simply and conveniently. Many of our members find these self-service tools helpful:

- Check on your claims.
- Find a doctor.
- Check the price of a drug and refill a prescription.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.
- Select to receive communications by email.
- Take your Health Assessment to learn about your health risks so you can address them.

Visit [anthem.com/guidedtourtour](https://www.anthem.com/guidedtourtour) to watch a video explaining how our website can help you.

### Do I have health and wellness benefits with my plan?

Yes. In fact, we have a set of tools and resources that can help you reach your health goals. They can also save you money on products and services for your health. Just go to [anthem.com](https://www.anthem.com) and click the *Health & Wellness* tab. Once you're a member, you can log in and see more.

Check out these health and wellness programs your employer is providing in addition to your health benefits:

**24/7 NurseLine** — Our registered nurses can answer your health questions wherever you are — any time, day or night.

**Future Moms** — Moms-to-be get personalized support and guidance from registered nurses to help them have a healthy pregnancy, a safe delivery and a healthy baby.

**ConditionCare** — Get the added support you may need if you have asthma, diabetes, heart disease, chronic obstructive pulmonary disease or heart failure. A nurse coach can answer questions about your health and help you reach your health goals based on your doctor's care plan. You can work with



## Frequently asked questions (FAQ)

dietitians, health educators, pharmacists and social workers to reach those goals and feel your best.

**ComplexCare** — If you have a serious health condition or a number of health issues that need extra care, a nurse coach will help answer your questions, work to coordinate your care, and help you effectively use your health benefits.

### How can Anthem help me save money?

You'll save money every time you go to a doctor in your plan — they've agreed to charge lower rates for Anthem members. But we'll also help save you money before you go to the doctor.

At [anthem.com](http://anthem.com), you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products. You can even print your own coupons for healthier groceries. Check out these cost saving programs your employer is also offering.

**Home Delivery Pharmacy** — You can save money and time by having your prescriptions delivered to your home.

**Site of Service** — If your plan includes Site of Service, you can get quality care for less money when you choose a freestanding, independent X-ray provider, ambulatory surgery center or lab from our network.

**Anthem Imaging Shopper** - If your doctor prescribes a CT or MRI for you, we may work with you and your doctor to help identify a lower cost facility in your area. And we can even help with scheduling your appointment.

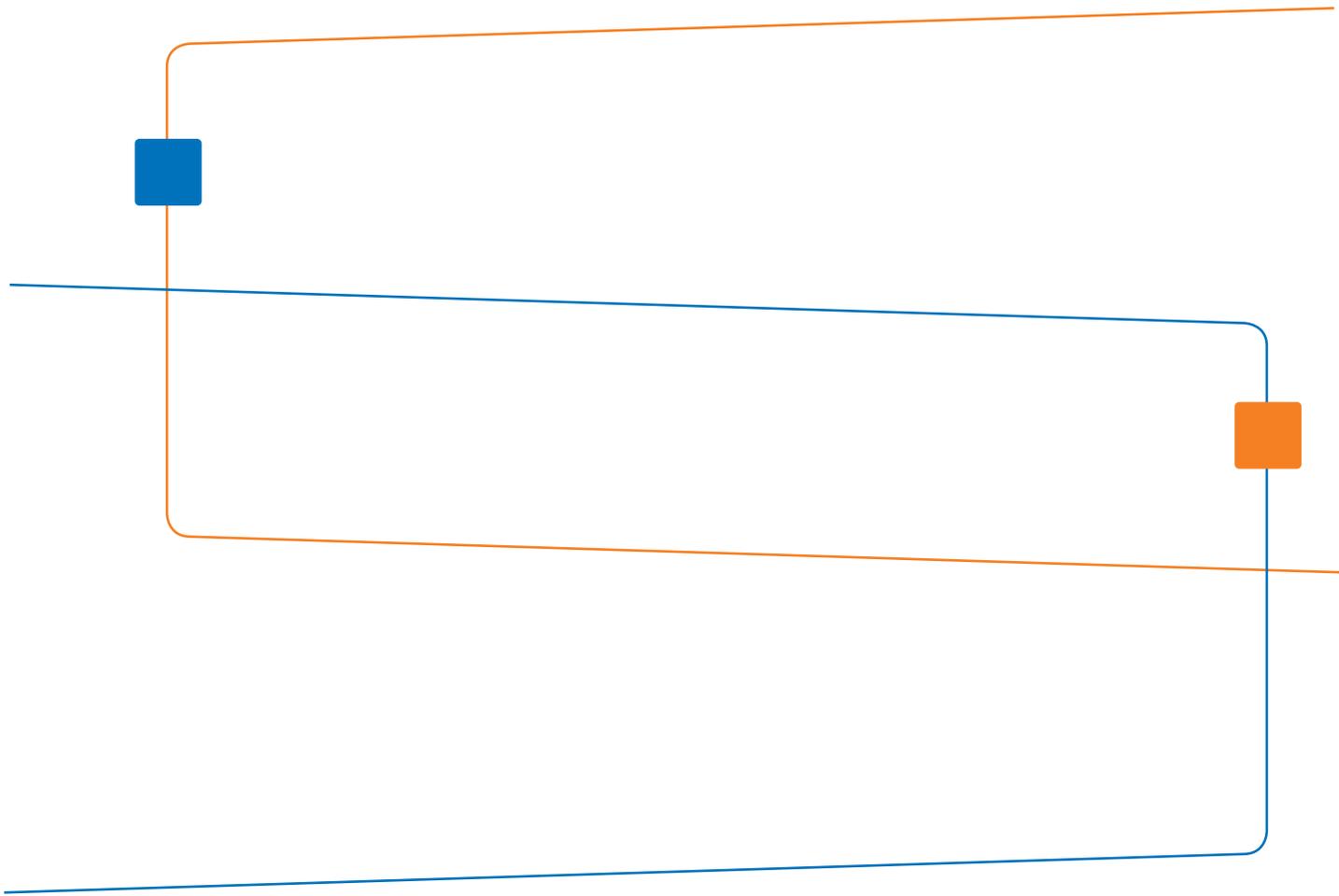
**LiveHealth Online** — Using LiveHealth Online, you can have a video visit with a board-certified doctor or therapist on your smartphone, tablet or computer with a webcam. It's easy to use and there when you need it. All you have to do is sign up to use it at [livehealthonline.com](http://livehealthonline.com) or download the app.

**Enhanced Personal Health Care** — We're helping doctors focus on the quality of care they give. They'll know your history, your specialists and your medications, and they'll coordinate your treatment with other doctors and health care providers. And, they'll get you the care you need when you need it, even after

hours. That way, they can take more time to listen to you so you don't feel as rushed.

# Your plan details

**In this next section, you'll find more information about your plan.** 





**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com](http://www.anthem.com) or by calling 1-800-451-1527.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>In-network: <b>\$2,000</b>/Individual; <b>\$4,000</b>/Family Out-of-network: <b>\$3,000</b>/Individual; <b>\$6,000</b>/Family Deductible is on a calendar year. Services <b>not subject to deductible</b> are noted in <b>Limitations &amp; Exceptions</b>.</p>	<p>You must pay all the costs up to the calendar year <b>deductible</b> amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. In-network providers: <b>\$5,000</b> Individual / <b>\$10,000</b> Family Out-of-network providers: <b>\$7,250</b> Individual / <b>\$14,500</b> Family</p>	<p>The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (per calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. <b>The out of pocket limits includes both medical and prescription drug cost shares.</b></p>
<p>What is <b>not included</b> in the <u>out-of-pocket limit</u>?</p>	<p>Costs associated with routine vision care, the cost of care when the benefit limits have been reached, the cost of non-covered services and amounts above the allowed amount for services.</p>	<p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

<p><b>Does this plan use a network of providers?</b></p>	<p>Yes. For a list of participating medical providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-451-1527.</p>	<p>If you use an in-network doctor or other health care <b>provider</b>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b>, or participating for <b>providers</b> in their <b>network</b>. See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b>.</p>
<p><b>Do I need a referral to see a specialist?</b></p>	<p>No.</p>	<p>You can see a <b>specialist</b> you choose for covered services without permission from this plan.</p>
<p><b>Are there services this plan doesn't cover?</b></p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b>.</p>



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
<p><b>If you visit a health care provider's office or clinic</b></p>	<p>Primary care visit Specialist visit Other practitioner office visit Preventive care/screening/immunization</p>	<p>\$30 copay/visit \$50 copay/visit \$25 copay/visit No cost share</p>	<p>40% Coinsurance 40% Coinsurance 40% Coinsurance 40% Coinsurance</p>	<p>Deductible does not apply in-network. Deductible does not apply in-network. Deductible does not apply in-network. Deductible does not apply in-network.</p>
<p><b>If you have a test</b></p>	<p>Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)</p>	<p>20% coinsurance 20% coinsurance</p>	<p>40% Coinsurance 40% Coinsurance</p>	<p>—————none————— Preauthorization required.</p>

**Questions:** Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 30

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com">www.anthem.com</a></p>	<p>Tier 1 - Generic</p>	<p>\$15 copay/ prescription for Retail \$38 copay / prescription for Mail order</p>	<p>\$15 copay/ prescription for Retail** Mail order not covered</p>	<p>Retail pharmacy drugs are limited to a 30-day supply. Maintenance medications are available at the retail level, 3 month supply at 3X retail copay. Mail order drugs are limited to a 90-day supply.</p>
	<p>Tier 2 – Preferred Brand</p>	<p>\$40 copay/ prescription for Retail \$100 copay / prescription for Mail order</p>	<p>\$40 copay/ prescription for Retail* Mail order not covered</p>	<p>If you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. <b>*You may also be subject to any costs above the allowed amount.</b></p>
	<p>Tier 3 – Non-Preferred Brand</p>	<p>\$75 copay/ prescription for Retail \$188 copay / prescription for Mail order</p>	<p>\$75 copay/ prescription for Retail* Mail order not covered</p>	<p>Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered.</p>

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 30

Coverage Period: 10/01/2016 – 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
	Tier 4 – Specialty Medications (limited to a 30 day supply per fill.)	20% coinsurance up to \$200 per prescription for Retail	20% coinsurance up to \$200 per prescription for Retail*	Must use our Specialty Pharmacy, Accredo, to dispense all Specialty Medications. Split fill program (14 day initial supply} applies to initial fill of Specialty drugs.
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	20% coinsurance	40% Coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	40% Coinsurance	_____none_____
	Emergency room services	20% coinsurance	40% Coinsurance	_____none_____
	Emergency medical transportation	20% coinsurance	40% Coinsurance	_____none_____
If you need immediate medical attention	Urgent care	\$30 PCP/\$50 specialist copay/visit	40% Coinsurance	Deductible does not apply in-network.
If you have a hospital stay	Facility fee (e.g, hospital room)	20% coinsurance	40% Coinsurance	Precertification required.
	Physician/surgeon fee	20% coinsurance	40% Coinsurance	_____none_____

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 30

Coverage Period: 10/01/2016 – 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<b>Outpatient office setting:</b> \$30 copay/ visit <b>Outpatient facility setting:</b> 20% coinsurance	40% Coinsurance	Deductible does not apply in-network in the Outpatient office setting.
	Mental/Behavioral health inpatient services	20% coinsurance	40% Coinsurance	Precertification required.
	Substance use disorder outpatient services	<b>Outpatient office setting:</b> \$30 copay/ visit <b>Outpatient facility setting:</b> 20% coinsurance	40% Coinsurance	Deductible does not apply in-network in the Outpatient office setting.
	Substance use disorder inpatient services	20% coinsurance	40% Coinsurance	Precertification required.
If you are pregnant	Prenatal and postnatal care	\$30 PCP/\$50 specialist copay/visit	40% Coinsurance	Routine pre/post-natal care (excluding inpatient stay & diagnostic testing); Deductible does not apply in-network.
	Delivery and all inpatient services	20% coinsurance	40% Coinsurance	—————none—————

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary

at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 30

Coverage Period: 10/01/2016 – 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% Coinsurance	100 visit limit per calendar year.
	Rehabilitation services	<b>Physical Therapy, Speech Therapy, Occupational Therapy:</b> 20% coinsurance/ visit	40% Coinsurance	30 combined visits for physical therapy and occupational therapy; 30 visits for speech therapy.
	Habilitation services	<b>Physical Therapy, Speech Therapy, Occupational Therapy:</b> 20% coinsurance	40% Coinsurance	30 combined visits for physical therapy and occupational therapy; 30 visits for speech therapy.
	Skilled nursing care	20% coinsurance	40% Coinsurance	100 day per stay limit; preauthorization required.
If your child needs dental or eye care	Durable medical equipment	20% coinsurance	40% Coinsurance	_____none_____
	Hospice service	No cost share	40% Coinsurance	_____none_____
	Eye exam	\$15 copay/ visit	\$30 allowance/visit	One eye exam per member per calendar year. Deductible does not apply in or out of network.
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids
- Cosmetic surgery
- Infertility treatment
- Dental care
- Long-term care
- Routine foot care

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Private duty nursing
- Autism Spectrum Disorder (for children from age 2 to 10)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-451-1527. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Questions:** Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield: Appeals, Attention Member Services, P.O. Box 27401, Richmond, VA 23279.

You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-EBSA (3272) or [www.dol/ebsa/healthreform](http://www.dol/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le solicitamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoo'wo'í úmizinigo t'áa diné k'éjigo, t'áa shoodí ba na' a'nhí ya sidahí bich'í naabí'í'kiid. Eí doo biigha daago ni ba'nija'go ho'aalagí'í bich'í hodiilini. Hai'daa'í uim'taago e'ya, t'áa shoodí diné ya atah halné'ígí ní béesh bee hane'í wólta' b'í'ki s'í niilígí'í bi'kéhgo bich'í hodiilini.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

**Questions:** Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$4,480
- **Patient pays** \$3,060

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$2,000
Copays	\$70
Coinsurance	\$1,060
Limits or exclusions	\$0
<b>Total</b>	<b>\$3,060</b>

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,320
- **Patient pays** \$3,080

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$2,000
Copays	\$1,000
Coinsurance	\$80
Limits or exclusions	\$0
<b>Total</b>	<b>\$3,080</b>

### Questions and answers about the Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

#### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

#### Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

#### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

#### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

#### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HIRAs) that help you pay out-of-pocket expenses.



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com](http://www.anthem.com) or by calling 1-800-451-1527.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>In-network: <b>\$0</b>                      Out-of-network: <b>\$500</b> / Individual;  <b>\$1,000</b> / Family  <b>Services subject to deductible are noted in Limitations &amp; Exceptions.</b></p>	<p>You must pay all the costs up to the calendar year <b>deductible</b> amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b>.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes.                      In-network providers:  <b>\$5,000</b> Individual / <b>\$10,000</b> Family                      Out-of-network providers:  <b>\$6,500</b> Individual / <b>\$13,000</b> Family</p>	<p>The calendar year <b>out-of-pocket limit</b> is the most you could pay during a coverage period (one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. <b>The out of pocket limits includes both medical and prescription drug cost shares.</b></p>
<p>What is <u>not included</u> in the <u>out-of-pocket limit</u>?</p>	<p>Costs associated with routine vision care, the cost of care when the benefit limits have been reached, the cost of non-covered services and amounts above the allowed amount for services.</p>	<p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>

<p><b>Does this plan use a network of providers?</b></p>	<p>Yes. For a list of participating medical providers, see <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-451-1527.</p>	<p>If you use an in-network doctor or other health care <b>provider</b>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b>, or participating for <b>providers</b> in their <b>network</b>. See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b>.</p>
<p><b>Do I need a referral to see a specialist?</b></p>	<p>No.</p>	<p>You can see a <b>specialist</b> you choose for covered services without permission from this plan.</p>
<p><b>Are there services this plan doesn't cover?</b></p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b>.</p>



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
<p><b>If you visit a health care provider's office or clinic</b></p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$30 copay/visit</p>	<p>30% Coinsurance</p>	<p>_____none_____</p>
	<p>Specialist visit</p>	<p>\$50 copay/visit</p>	<p>30% Coinsurance</p>	<p>_____none_____</p>
	<p>Other practitioner office visit</p>	<p>\$30 PCP/\$50 specialist copay/visit</p>	<p>30% Coinsurance</p>	<p>Spinal manipulation and manual medical therapy limited to 30 visits per calendar year.</p>
<p><b>If you have a test</b></p>	<p>Preventive care/screening/immunization</p>	<p>No cost share</p>	<p>30% Coinsurance</p>	<p>_____none_____</p>
	<p>Diagnostic test (x-ray, blood work)</p>	<p>20% coinsurance</p>	<p>30% Coinsurance</p>	<p>_____none_____</p>
	<p>Imaging (CT/PET scans, MRIs)</p>	<p>20% coinsurance</p>	<p>30% Coinsurance</p>	<p>Preauthorization required.</p>

**Questions:** Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 20

Coverage Period: 10/01/2016 – 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com">www.anthem.com</a></p>	Tier 1 - Generic	\$15 copay/ prescription for Retail \$38 copay / prescription for Mail order	\$15 copay/ prescription for Retail* Mail order not covered	Retail pharmacy drugs are limited to a 30-day supply. Maintenance medications are available at the retail level, 3 month supply at 3X retail copay. Mail order drugs are limited to a 90-day supply.
	Tier 2 – Preferred Brand	\$40 copay/ prescription for Retail \$100 copay / prescription for Mail order	\$40 copay/ prescription for Retail* Mail order not covered	If you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. <b>*You may also be subject to any costs above the allowed amount.</b>
	Tier 3 – Non-Preferred Brand	\$75 copay/ prescription for Retail \$188 copay / prescription for Mail order	\$75 copay/ prescription for Retail* Mail order not covered	Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered.

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 20

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
If you have outpatient surgery	Tier 4 – Specialty Medications (limited to a 30 day supply per fill.)	20% coinsurance up to \$200 per prescription for Retail	20% coinsurance up to \$200 per prescription for Retail*	Must use our Specialty Pharmacy, Accredo, to dispense all Specialty Medications. Split fill program (14 day initial supply) applies to initial fill of Specialty drugs.
	Facility fee (e.g, ambulatory surgery center)	\$200 copay plus 20% coinsurance/visit	30% Coinsurance	
If you need immediate medical attention	Physician/surgeon fees	No charge	30% Coinsurance	_____none_____
	Emergency room services	\$200 copay plus 20% coinsurance/visit; 20% coinsurance for physician services	30% Coinsurance	_____none_____
	Emergency medical transportation	\$150 copay/transport	30% Coinsurance	_____none_____
	Urgent care	\$30 PCP/\$50 specialist copay/visit	30% Coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g, hospital room)	\$300 copay plus 20% coinsurance/admission	30% Coinsurance	Pre-certification required.
	Physician/surgeon fee	20% coinsurance	30% Coinsurance	_____none_____

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 20

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	<b>Outpatient office setting:</b> \$30 copay/ visit <b>Outpatient facility setting:</b> 20% coinsurance/visit	30% Coinsurance	_____none_____
	Mental/Behavioral health inpatient services	\$300 copay plus 20% coinsurance/admission; 20% coinsurance for physician services	30% Coinsurance	Pre-certification required.
	Substance use disorder outpatient services	<b>Outpatient office setting:</b> \$30 copay/ visit <b>Outpatient facility setting:</b> 20% coinsurance/visit	30% Coinsurance	_____none_____
	Substance use disorder inpatient services	\$300 copay plus 20% coinsurance/admission; 20% coinsurance for physician services	30% Coinsurance	Pre-certification required.
If you are pregnant	Prenatal and postnatal care	\$200 copay/pregnancy \$300 copay plus 20% coinsurance/admission; 20% coinsurance for physician services	30% Coinsurance	Routine pre/post-natal care (excluding inpatient stay & diagnostic testing)
	Delivery and all inpatient services		30% Coinsurance	_____none_____

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

# City of Salem & Salem City Schools- KeyCare 20

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use Network Providers	Your Cost If You Use Non-Network Providers	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	\$30 copay/ visit	30% Coinsurance	100 visit limit per calendar year.
	Rehabilitation services	<b>Physical Therapy:</b> \$50 copay plus 20% coinsurance/ visit.	30% Coinsurance	30 combined visits for physical therapy and occupational therapy; 30 visits for speech therapy.
		<b>Speech/ Occupational Therapy:</b> 20% coinsurance		
	Habilitation services	<b>Physical Therapy:</b> \$50 copay plus 20% coinsurance/ visit.	30% Coinsurance	30 combined visits for physical therapy and occupational therapy; 30 visits for speech therapy.
		<b>Speech/ Occupational Therapy:</b> 20% coinsurance		
		20% coinsurance		
	Skilled nursing care	20% coinsurance	30% Coinsurance	100 day per stay limit; preauthorization required.
	Durable medical equipment	20% coinsurance	30% Coinsurance	_____none_____
	Hospice service	No cost share	30% Coinsurance	_____none_____
	If your child needs dental or eye care	Eye exam	\$15 copay/ visit	\$30 allowance/visit
Glasses		Not covered	Not covered	_____none_____
Dental check-up		Not covered	Not covered	_____none_____

Questions: Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids
- Cosmetic surgery
- Infertility treatment
- Dental care
- Long-term care
- Routine foot care

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Private duty nursing
- Autism Spectrum Disorder (for children from age 2 to 10)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-451-1527. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Questions:** Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield: Appeals, Attention Member Services, P.O. Box 27401, Richmond, VA 23279.

You may also contact the Department of Labor’s Employee Benefits Security Administration at 1-866-EBSA (3272) or [www.dol/ebsa/healthreform](http://www.dol/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł ímízínigo t'áa diné k'éjugo, t'áa shoodí ba na' ałnłhí ya sidáhí bich'í naabidłłkiid. Eí doo bügha daago ni ba'nija'go ho'aalagú bich'í hodiłłni. Hai'daaq imi'taago eiya, t'áa shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bíki sí niłłgú bí'kéhgo bich'í hodiłłni.

—To see examples of how this plan might cover costs for a sample medical situation, see the next page.

**Questions:** Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$6,040
- **Patient pays** \$1,500

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$520
Coinsurance	\$980
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,500</b>

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,060
- **Patient pays** \$1,340

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$1,000
Coinsurance	\$340
Limits or exclusions	\$0
<b>Total</b>	<b>\$1,340</b>

**Questions:** Call 1-800-451-1527 or visit us at [www.anthem.com](http://www.anthem.com)

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-451-1527 to request a copy.

### Questions and answers about the Coverage Examples:

#### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

#### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

#### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

#### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

#### Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

#### Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HIRAs) that help you pay out-of-pocket expenses.



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.anthem.com](http://www.anthem.com) or by calling 1-800-582-6941.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>For in-network providers AND out-of-network providers combined, per calendar year:  <b>\$3,000</b> Individual;  <b>\$6,000</b> Family                      Services not subject to deductible are noted in Limitations &amp; Exceptions.</p>	<p>You must pay all the costs up to the calendar year <u>deductible</u> amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u>. <b>No one family member will pay more than the \$3,000 Individual deductible per calendar year.</b></p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes.                      In-network providers:  <b>\$4,000</b> Individual ;  <b>\$8,000</b> Family                      Out-of-network providers:  <b>\$6,000</b> Individual ;  <b>\$12,000</b> Family</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (per calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. <b>The out of pocket limits includes both medical and prescription drug cost shares.</b></p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Routine vision care, the cost of care when the benefit limits have been reached, the cost of non-covered services and amounts above the allowed amount for services.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Is there an overall annual limit on what</p>	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

the plan pays?		If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Does this plan use a <b>network of providers</b> ?	Yes. For a list of <b>providers</b> , see <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-582-6941.	
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b> .
	<ul style="list-style-type: none"> <li>• <b>Copayments</b> are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.</li> <li>• <b>Coinsurance</b> is <i>your</i> share of the costs of a covered service, calculated as a percent of the <b>allowed amount</b> for the service. For example, if the plan's <b>allowed amount</b> for an overnight hospital stay is \$1,000, your <b>coinsurance</b> payment of 20% would be \$200. This may change if you haven't met your <b>deductible</b>.</li> <li>• The amount the plan pays for covered services is based on the <b>allowed amount</b>. If an out-of-network <b>provider</b> charges more than the <b>allowed amount</b>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <b>allowed amount</b> is \$1,000, you may have to pay the \$500 difference. (This is called <b>balance billing</b>.)</li> <li>• This plan may encourage you to use <b>in-network providers</b> by charging you lower <b>deductibles</b>, <b>copayments</b> and <b>coinsurance</b> amounts.</li> </ul>	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <b>provider's office</b> or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	_____none_____
	Specialist visit	0% coinsurance	20% coinsurance	
	Other practitioner office visit	0% coinsurance	20% coinsurance	Spinal manipulation and other manual medical intervention limited to 30 visits per calendar year combined for in and out-of-network.
	Preventive care/screening/immunization	No Charge	20% coinsurance	Deductible does not apply in-network.

# City of Salem & Salem City Schools - HSA

Coverage Period: 10/01/2016 – 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: HSA

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<p><b>If you have a test</b></p> <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com">www.anthem.com</a></p>	<p>Diagnostic test (x-ray, blood work)</p> <p>Imaging (CT/PET scans, MRIs)</p>	<p>0% coinsurance</p> <p>0% coinsurance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p>	<p>_____none_____</p> <p>_____none_____</p>
	<p>Tier 1 (\$3,000 individual/ \$6,000 family overall deductible applies)</p>	<p>\$10 copay/ prescription for Retail</p> <p>\$10 copay / prescription for Mail order</p>	<p>*\$10 copay/ prescription for Retail</p> <p>Mail order not covered</p>	<p>Retail pharmacy drugs are limited to a 30-day supply. Maintenance medications are available at the retail level, 3 month supply at 3X retail copay. Mail order drugs are limited to a 90-day day supply.</p>
	<p>Tier 2 (\$3,000 individual/ \$6,000 family overall deductible applies)</p>	<p>\$30 copay/ prescription for Retail</p> <p>\$60 copay / prescription for Mail order</p>	<p>*\$30 copay/ prescription for Retail</p> <p>Mail order not covered</p>	<p>If you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy.</p> <p><b>*You may also be subject to any costs above the allowed amount.</b></p>
	<p>Tier 3 (\$3,000 individual/ \$6,000 family overall deductible applies);</p> <p><b>For tier 3, copay or coinsurance whichever is greater up to \$200 per script retail and \$400 per script mail.</b></p>	<p>The greater of \$50 copay/ or 20% coinsurance/ prescription for Retail</p> <p>The greater of \$150 copay or 20% coinsurance/ prescription for Mail order</p>	<p>*The greater of \$50 copay/ or 20% coinsurance/ prescription for Retail</p> <p>Mail order not covered</p>	<p>Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require prior authorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary prior authorization is not obtained, the drug may not be covered.</p>

Questions: Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

# City of Salem & Salem City Schools - HSA

Coverage Period: 10/01/2016 – 09/30/2017  
 Coverage for: Individual/Family | Plan Type: HSA

## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	<p>Tier 4 – Specialty Medications (limited to a 30 day supply per fill.) (\$3,000 individual/ \$6,000 family overall deductible applies);</p> <p><b>For tier 4, copay or coinsurance whichever is greater up to \$200 per script retail and \$400 per script mail.</b></p>	<p>The greater of \$50 copay/ or 20% coinsurance/ prescription for Retail</p> <p>The greater of \$150 copay or 20% coinsurance/ prescription for Mail order</p>	<p>*The greater of \$50 copay/ or 20% coinsurance/ prescription for Retail</p> <p>Mail order not covered</p>	<p>Must use our Specialty Pharmacy, Accredo, to dispense all Specialty Medications. Split fill program (14 day initial supply} applies to initial fill of Specialty drugs.</p>
<b>If you have outpatient surgery</b>	<p>Facility fee (e.g., ambulatory surgery center)</p> <p>Physician/surgeon fees</p>	<p>0% coinsurance</p> <p>0% coinsurance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p>	<p>_____none_____</p> <p>_____none_____</p>
<b>If you need immediate medical attention</b>	<p>Emergency room services</p> <p>Emergency medical transportation</p> <p>Urgent care</p>	<p>0% coinsurance</p> <p>0% coinsurance</p> <p>0% coinsurance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>_____none_____</p> <p>_____none_____</p> <p>_____none_____</p>
<b>If you have a hospital stay</b>	<p>Facility fee (e.g., hospital room)</p> <p>Physician/surgeon fee</p>	<p>0% coinsurance</p> <p>0% coinsurance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p>	<p>Pre-certification is required.</p> <p>_____none_____</p>
<b>If you have mental health, behavioral health, or substance abuse needs</b>	<p>Mental/Behavioral health outpatient services</p> <p>Mental/Behavioral health inpatient services</p> <p>Substance use disorder outpatient services</p> <p>Substance use disorder inpatient services</p>	<p>0% coinsurance</p> <p>0% coinsurance</p> <p>0% coinsurance</p> <p>0% coinsurance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p> <p>20% coinsurance</p>	<p>Pre-certification is required.</p> <p>_____none_____</p> <p>Pre-certification is required.</p> <p>_____none_____</p>
<b>If you are pregnant</b>	<p>Prenatal and postnatal care</p> <p>Delivery and all inpatient services</p>	<p>0% coinsurance</p> <p>0% coinsurance</p>	<p>20% coinsurance</p> <p>20% coinsurance</p>	<p>_____none_____</p> <p>_____none_____</p>

Questions: Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

# City of Salem & Salem City Schools - HSA

Coverage Period: 10/01/2016 – 09/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: HSA

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Limited to 90 visits per calendar year. Combined in and out-of-network.
	Rehabilitation services	0% coinsurance	20% coinsurance	30 combined visits for physical therapy and occupational therapy; 30 visits for speech therapy.
	Habilitation services	0% coinsurance	20% coinsurance	_____none_____
	Skilled nursing care	0% coinsurance	20% coinsurance	100 day per stay limit; preauthorization required.
	Durable medical equipment	0% coinsurance	20% coinsurance	_____none_____
	Hospice service	0% coinsurance	20% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	\$15 copay/ visit	\$30 allowance/visit	One eye exam per member per calendar year. Deductible does not apply.
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Heating aids
- Cosmetic surgery
- Infertility treatment
- Dental care
- Long-term care
- Routine foot care

Questions: Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Private-duty nursing
- Autism Spectrum Disorder

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan at 1-800-582-6941. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield: Appeals, Attention Member Services, P.O. Box 27401, Richmond, VA 23279.

You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-EBSA (3272) or [www.dol/ebsa/healthreform](http://www.dol/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

### Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol ímízínigo t'áa diné k'éjúgo, t'áa shoodí ba na' a'lníhí ya sidáhí bich'í naabídtítkiid. Eí doo biúgha daago ni ba'nijá'go ho'aalagú bich'í hodiilní. Hai'daaq imi'taago eíya, t'áa shoodí diné ya atáh halné'ígú ní béesh bee hane'í wólta' bí'ki sí'milígú bí'kéhgo bich'í hodiilní.

\_\_\_\_\_ *To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$4,370
- **Patient pays** \$3,170

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$3,170</b>

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$2,120
- **Patient pays** \$3,280

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$3,000
Copays	\$200
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$3,280</b>

## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.com).

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

Choose from 3 Medical Plans:

1. Core KeyCare 30 PPO with \$15/\$40/\$75/20% Drug plan.
2. Buy-up KC20 PPO with \$15/\$40/\$75/20% Drug plan.
3. Buy-down Lumenos HDHP-HSA with \$10/\$30/\$50 or 20%/\$50 or 20%, after deductible Drug plan.

All plans use the KeyCare PPO/BCBS PPO Bluecard national network of providers.

All medical plans include the following:

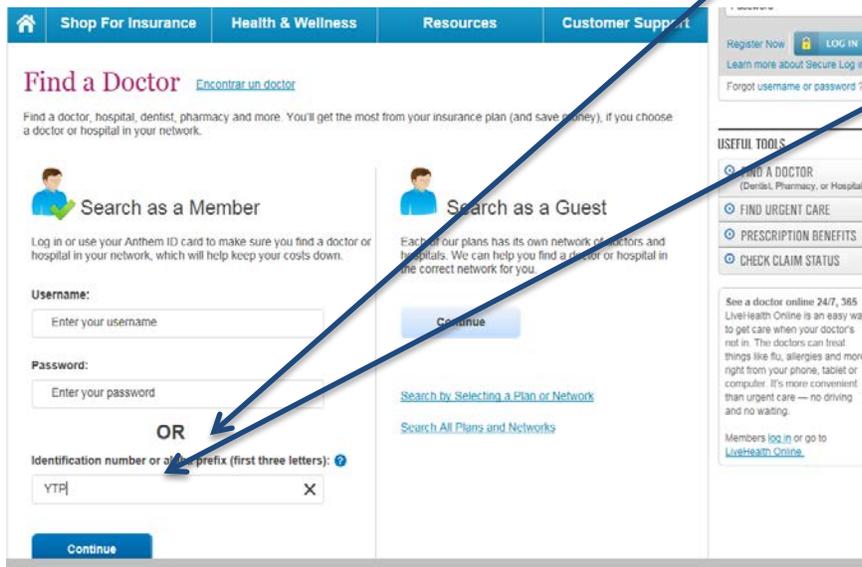
- Preventive Care services covered with no Member cost share when using in-network providers. *Please note any services that are not done and/or billed as Preventive Care classified services will be considered as Diagnostic services and subject to regular plan provisions/benefit levels.*
- An annual calendar year routine eye exam for a \$15 copay when using a BlueView Vision (BVV) participating provider. The BVV program also offers discounts on frames and lenses.

# The fastest way to search the Anthem.com FindADoctor tool for KeyCare PPO & National BlueCard PPO participating providers. The Lumenos HDHP-HSA plan uses the same network of participating providers.



1. From the Anthem.com landing page under “Useful Tools” on the right hand side of the screen, click on the “FindADoctor” icon.

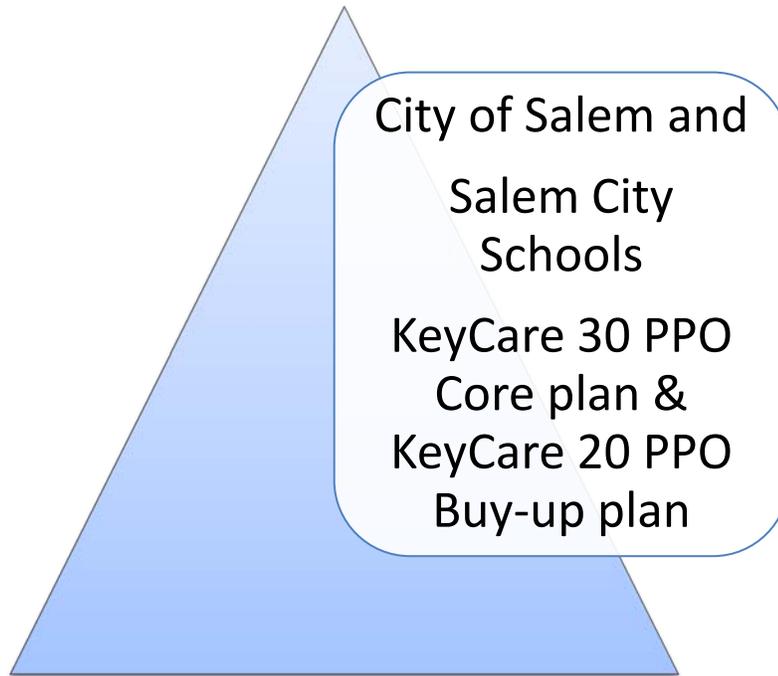
2. On the next screen (example shown here), the fastest way to find KC PPO providers is to use the Anthem ID card three letter alpha prefix code that is listed on the Anthem ID cards.



3. The three letter alpha prefix for the KeyCare PPO & National Bluecard PPO participating provider network is “YTP”. By entering the “YTP” alpha prefix into the “FindADoctor” search tool, the system will automatically only search for providers that are Keycare PPO/National BlueCard PPO participating providers. The three letter alpha prefix for the Lumenos HDHP-HSA is “YTC”, but this plan uses the same KeyCare PPO/National BlueCard PPO network of providers.

[https://www.anthem.com/health-insurance/provider-directory/searchcriteria?q=\\*iniPg8rTp1aSQi2LWZJpzeTl1a/a0OuNIVA06ZP1ypY=&brand=abcbs](https://www.anthem.com/health-insurance/provider-directory/searchcriteria?q=*iniPg8rTp1aSQi2LWZJpzeTl1a/a0OuNIVA06ZP1ypY=&brand=abcbs)

# Summary of Benefits



Effective October 1, 2016-September 30, 2017

## Anthem KeyCare 30 PPO Plan: \$2,000 In-Network Deductible

10/01/16-9/30/17

In-Network Services	You Pay
<b>Preventive Care Services</b>	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.  * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	<b>No cost share</b>
<b>Routine Vision</b>	
<ul style="list-style-type: none"> <li>○ annual routine eye exam <i>Plus valuable discounts on eyewear</i></li> </ul>	<b>\$15</b> for each visit
<b>Doctor Visits</b>	
<ul style="list-style-type: none"> <li>○ office visits</li> <li>○ urgent care visits</li> <li><b>*If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)</b></li> <li>○ mental health and substance abuse office visit</li> <li>○ spinal manipulation and other manual medical intervention visits (30 visit limit)</li> </ul>	<ul style="list-style-type: none"> <li>○ pre- and postnatal office visits*</li> <li>○ home visits</li> </ul> <b>\$30</b> for each visit to a PCP <b>\$50</b> for each visit to a specialist
<b>All Other In-Network Services</b>	
You will pay all the costs associated with care until you have paid \$2,000 in one calendar or plan year. This is known as your deductible.  <ul style="list-style-type: none"> <li>○ If two people are covered under your plan, each of you will pay the first \$2,000 of the cost of your care (\$4,000 total).</li> <li>○ If three or more people are covered under your plan, together you will pay the first \$4,000 of the cost of your care. However, the most one family member will pay is \$2,000.</li> </ul> <b>Once you reach your deductible you pay:</b>	
<b>Autism Spectrum Disorder (ASD) – For children from age 2 through 10</b>	
<ul style="list-style-type: none"> <li>○ diagnosis and treatment of autism spectrum disorder including:               <ul style="list-style-type: none"> <li>○ behavioral health treatment*</li> <li>○ psychiatric care</li> <li>○ therapeutic care**</li> </ul> </li> </ul> <b>* Mental Health Services</b> <b>**Unlimited physical, occupational and speech therapy.</b>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> <li>○ applied behavioral analysis</li> </ul>	<b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services
<b>Early Intervention – For children from birth up to age 3</b>	
<ul style="list-style-type: none"> <li>○ unlimited per member per calendar year up to age 3</li> </ul>	Member cost shares will be dependent on the services rendered.
<b>Other Outpatient Services</b>	
<ul style="list-style-type: none"> <li>○ shots and therapeutic injections</li> <li>○ medical appliances, supplies and medications, including infusion medications</li> <li>○ durable medical equipment</li> <li>○ diagnostic lab services</li> <li>○ in-office surgery</li> <li>○ chemotherapy (not given orally), IV, radiation, cardiac and respiratory therapy</li> </ul> <b>*Limit does not apply to Autism Spectrum Disorder.</b>	<ul style="list-style-type: none"> <li>○ physical and occupational therapy visits in an office setting (30 combined visits)*</li> <li>○ speech therapy visits in an office setting (30 visit limit)*</li> <li>○ dialysis</li> <li>○ diagnostic x-rays</li> <li>○ ambulance travel</li> </ul> <b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services

Your benefit period is a calendar year. A calendar year means your benefit period runs from January through December.

For benefits listed with specific limits all services received in the calendar year for that benefit are applied to that limit (whether received in or out-of-network).

In-Network Services	You Pay
<b>Other Outpatient Services - Continued</b>	
<ul style="list-style-type: none"> <li>○ diabetic supplies, equipment and education</li> </ul>	Member cost shares will be dependent on the services rendered.
<b>Outpatient Services in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ physical therapy and occupational therapy (30 combined visits)*</li> <li>○ speech therapy (30 visit limit)*</li> <li>○ partial day mental health and substance abuse services</li> <li>○ emergency room</li> <li>○ surgery</li> </ul> <p><i>*Limit does not apply to Autism Spectrum Disorder.</i></p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<b>Care at Home</b>	
<ul style="list-style-type: none"> <li>○ home health care (100 visits)</li> <li>○ private duty nursing limited to 16 hours per member per calendar year</li> </ul> <p><i>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.</i></p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> <li>○ hospice care</li> </ul>	<b>No cost share</b>
<b>Inpatient Stays in a Network Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ semi-private room, intensive care or similar unit</li> <li>○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services.</li> <li>○ skilled nursing facility care (100 days for each admission)</li> </ul>	20% of the amount the health care professionals in our network have agreed to accept for their services
<b>Out-of-Network Services</b>	
<b>Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits</b>	
<p>It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$3,000 in one calendar year. This is called your out-of-network deductible.</p> <ul style="list-style-type: none"> <li>○ If two people are covered under your plan, each of you will pay the first \$3,000 of the cost of your care (\$6,000 total).</li> <li>○ If three or more people are covered under your plan, together you will pay the first \$6,000 of the cost of your care. However, the most one family member will pay is \$3,000.</li> </ul> <p>Once you have reached this amount, when you receive covered services we will pay 60% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$3,000 out-of-network deductible) and you will pay the rest of what the professional charges.</p>	
<b>Out-of-Pocket Maximums</b>	
<b>What You Will Pay for Covered Services in One Calendar Year</b>	
<b>When using network professionals</b>	
<p>If you are the only one covered by your plan, you will pay \$5,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*</p>	
<ul style="list-style-type: none"> <li>○ If two people are covered under your plan, each of you will pay \$5,000 (\$10,000 total).</li> <li>○ If three or more people are covered under your plan, together you will pay \$10,000. However, no family member will pay more than \$5,000 toward the limit.</li> </ul>	
<b>When not using network professionals</b>	
<p>If you are the only one covered by your plan, you will pay \$7,250 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*</p>	
<ul style="list-style-type: none"> <li>○ If two people are covered under your plan, each of you will pay \$7,250 (\$14,500 total).</li> <li>○ If three or more people are covered under your plan, together you will pay \$14,500. However, no family member will pay more than \$7,250 toward the limit.</li> </ul>	
<p><b>The in-network calendar year out-of-pocket maximum includes in-network medical copays, deductible, coinsurance, and in-network pharmacy copays &amp; coinsurance.</b></p>	
<p><b>*The following do not count toward the calendar year out-of-pocket maximum:</b></p>	
<ul style="list-style-type: none"> <li>○ your share of the cost of routine vision care</li> <li>○ the cost of care received when the benefit limits have been reached</li> <li>○ the cost of services and supplies not covered under your Anthem KeyCare 30 plan</li> <li>○ the additional amount health care professionals not in our network may bill you when their charge is more than what we pay</li> </ul>	

*This benefits overview insert is only one piece of your entire enrollment package.  
See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the federal health care reform laws. Anthem believes the benefits are compliant with applicable law, but they have not been approved by the Virginia Bureau of Insurance at this time. We may be required to make additional changes to this summary of benefits

## Anthem KeyCare 20 PPO Plan: \$0 In-Network Deductible

10/01/16-9/30/17

In-Network Services	You Pay
<b>Preventive Care Services</b> Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.  * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	<b>*No cost share</b>
<b>Routine Vision</b> <ul style="list-style-type: none"> <li>○ annual routine eye exam</li> </ul> Plus valuable discounts on eyewear	<b>\$15</b> for each visit
<b>Doctor Visits</b>  <ul style="list-style-type: none"> <li>○ office visits</li> <li>○ urgent care visits</li> <li>○ home visits</li> <li>○ spinal manipulations and other manual medical intervention visits (30 visit limit)</li> <li>○ in office surgery</li> </ul>	<b>\$30</b> for each visit to a PCP <b>\$50</b> for each visit to a specialist
<b>Autism Spectrum Disorder (ASD) – For children from age 2 through 6</b>  <ul style="list-style-type: none"> <li>○ diagnosis and treatment of autism spectrum disorder including:                             <ul style="list-style-type: none"> <li>○ behavioral health treatment*</li> <li>○ psychiatric care</li> <li>○ therapeutic care**</li> <li>○ pharmacy care</li> <li>○ psychological care</li> </ul> </li> </ul> * <b>Mental Health Services</b> ** <b>Unlimited physical, occupational and speech therapy.</b>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> <li>○ applied behavioral analysis</li> </ul>	<b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services
<b>Early Intervention – For children from birth through age 2</b>  <ul style="list-style-type: none"> <li>○ unlimited per member per calendar year up to age 3</li> </ul>	Member cost shares will be dependent on the services rendered.
<b>Labs, Diagnostic X-rays and Other Outpatient Services</b>  <ul style="list-style-type: none"> <li>○ diagnostic lab services</li> <li>○ diagnostic x-rays</li> <li>○ dialysis</li> <li>○ infusion services</li> <li>○ shots and therapeutic injections, including infusion medications</li> <li>○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy</li> </ul>	<b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> <li>○ diabetic supplies, equipment and education</li> </ul>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> <li>○ durable medical equipment</li> </ul>	<b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services.
<ul style="list-style-type: none"> <li>○ ambulance travel</li> </ul>	<b>\$150</b> copayment per transport

**For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-network).**

In-Network Services	You Pay
<b>Outpatient Visits in a Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ physical therapy and occupational therapy (30 combined visits)*</li> <li>○ speech therapy (30 visit limit)*</li> </ul> <p><i>*Limit does not apply to Early Intervention and Autism Spectrum Disorder.</i></p>	<p><b>PT - \$50 copay plus 20%</b> of the amount the health care professionals in our network have agreed to accept for their services; <b>OT and ST, 20%</b> of the amount the health care professionals in our network have agreed to accept for their services.</p>
<ul style="list-style-type: none"> <li>○ surgery</li> </ul> <p><i>*For the services billed by the doctor, you will pay an additional \$30 or \$50 depending on the type of doctor who treats you.</i></p>	<p><b>\$200 plus 20%</b> of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> <li>○ diabetic supplies, equipment and education</li> </ul>	<p>Member cost shares will be dependent on the services rendered.</p>
<b>Emergency Care</b>	
<ul style="list-style-type: none"> <li>○ emergency room</li> </ul>	<p><b>\$200 plus 20%</b> of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> <li>○ emergency room physician services</li> </ul>	<p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>
<b>Mental Health and Substance Abuse Outpatient Services</b>	
<ul style="list-style-type: none"> <li>○ office visits</li> </ul>	<p><b>\$30 for each visit</b></p>
<ul style="list-style-type: none"> <li>○ outpatient facility (including partial day mental health and substance abuse services)</li> <li>○ outpatient facility professional provider services</li> </ul>	<p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>
<b>Care at Home</b>	
<ul style="list-style-type: none"> <li>○ hospice care</li> </ul>	<p><b>No cost share</b></p>
<ul style="list-style-type: none"> <li>○ home health care (100 visits)</li> <li>○ private duty nursing limited to 16 hours per member per calendar year*</li> </ul> <p><i>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charges.</i></p>	<p><b>\$30 copay per visit</b></p> <p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services.</p>
<b>Maternity</b>	
<ul style="list-style-type: none"> <li>○ all routine pre- and postnatal care (excluding inpatient stays)</li> </ul>	<p><b>\$200 per pregnancy</b></p>
<ul style="list-style-type: none"> <li>○ diagnostic test</li> <li>○ non-stress tests and other fetal monitor procedures</li> <li>○ ultrasounds</li> </ul>	<p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>
<b>Inpatient Stays in a Network Hospital or Facility</b>	
<ul style="list-style-type: none"> <li>○ semi-private room, intensive care or similar unit</li> </ul> <p><i>*You do not have to pay another inpatient copay if you are readmitted for the same or related condition within 90 days of the day you went home.</i></p>	<p><b>\$300 plus 20%</b> of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> <li>○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services</li> </ul>	<p><b>20%</b> of the amount the health care professionals in our network have agreed to accept for their services</p>

## Out-of-Network Services

### Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$400 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first \$500 of the cost of your care (\$1,000 total).
- If three or more people are covered under your plan, together you will pay the first \$1,000 of the cost of your care. However, the most one family member will pay is \$500.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$400 out-of-network deductible) and you will pay the rest of what the professional charges.

## Out-of-Pocket Maximums

### What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

#### When using network professionals

If you are the only one covered by your plan, you will pay \$5,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum\*.

- If two people are covered under your plan, each of you will pay \$5,000 (\$10,000 total).
- If three or more people are covered under your plan, together you will pay \$5,000. However, no family member will pay more than \$5,000 toward the limit.

#### When not using network professionals

If you are the only one covered by your plan, you will pay \$6,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum\*.

- If two people are covered under your plan, each of you will pay \$6,500 (\$13,000 total).
- If three or more people are covered under your plan, together you will pay \$13,000. However, no family member will pay more than \$6,500 toward the limit.

**The in-network calendar year out-of-pocket maximum includes in-network medical copays and coinsurance, and in-network pharmacy copays & coinsurance.**

#### \*The following do not count toward the calendar year out-of-pocket maximum:

- your share of the cost routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 20 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

*This benefits overview insert is only one piece of your entire enrollment package.  
See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

# Your prescription drug plan

## KeyCare 20 PPO and KeyCare 30 PPO Prescription Drug program

Your Prescription Drug 15-40-75-20% Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay	Tier 4 Copay
Up to a 30-day medication supply at participating pharmacies	\$15	\$40	\$75	20% coinsurance with a \$200 prescription maximum*
Up to a 90-day medication supply delivered to your home	\$38	\$100	\$188	Not Applicable
Up to a 90-day medication supply purchased at a participating** retail pharmacy	\$45	\$120	\$225	Not Applicable

*\*Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.*

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum. Please refer to the benefit summary included with your enrollment brochure for the out-of-pocket maximum established for your medical and pharmacy benefit.

### 30-Day Retail Pharmacy Network

Our network includes more than 69,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

### Retail 90 Pharmacy

Retail 90\*\* is a unique network that offers more ways for you to get the maintenance medications you need. Maintenance medications are drugs taken on an ongoing basis for conditions such as asthma, diabetes or high cholesterol. Through Retail 90, you can choose to get a 90-day supply of medications from a participating retail pharmacy.

\*\*Approximately 98% of the pharmacies in our network participate in the Retail 90 program. Be sure to check with your local pharmacy to verify their participation status prior to placing your 90 day retail prescription order.

To make sure your pharmacy's in our network, visit [anthem.com](http://anthem.com) and select Find a Doctor which will take you to the list of providers, pharmacies and hospitals who participate in our network.

### Home Delivery Pharmacy

Members needing maintenance medications also have the option to use our Home Delivery Pharmacy service. Our preferred Home Delivery Pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- 90-day maintenance medications for less cost than if you purchased them at a retail location
- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

### Ordering refills

With home delivery, you don't have to worry about running out of medication. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

# Your prescription drug plan (continued)

## Specialty Pharmacy

Accredo, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. Most specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail (Transplant and HIV/AIDS medications are covered up to a 90 day supply). They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn's Disease
- Growth Hormone
- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Accredo CareLogic® programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication and side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments. Call 800-870-6419 to learn about how CareLogic can help you better manage your health condition.

## Drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs. We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit [anthem.com](http://anthem.com). Click on "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the Drug List on this page. If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

## Preferred Generics

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of a brand drug – but usually at a lower cost.

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

## Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

# Your prescription drug plan (continued)

## Step Therapy

Step Therapy may be required for certain drugs. Step Therapy refers to the process in which you may be required to use one type of medication before benefits are available for another. Step Therapy helps you and your doctor choose drugs that are safe, affordable and right for you. When your doctor prescribes a drug that requires step therapy, a message is sent to your pharmacy. This lets the pharmacist know you must first try a different, similar drug that's covered by your plan. The pharmacist will call your doctor to get a prescription for the new drug.

## Quantity Limit

Taking too much medicine or using it too often isn't safe. And it may even drive up your health care costs. That's why your plan may limit the amount of medicine that's covered for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you.

The Drug List also includes this information. To view it, visit [anthem.com](http://anthem.com). Click on "Customer Care" in the top-right corner. Select your state, and then click on "Download Forms." You'll find the Drug List on this page.

*Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.*

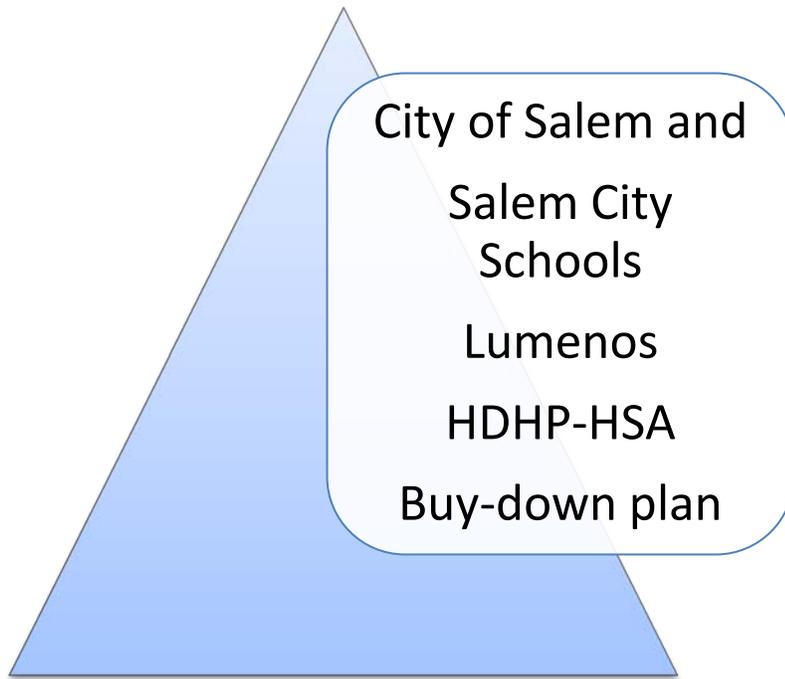
*Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliates, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.*

*This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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.

# Summary of Benefits



Effective October 1, 2016-September 30, 2017

# Find the answers here

## Frequently asked questions (FAQs) about your City of Salem & Salem City Schools HDHP-HSA with HSA

### Table of contents

Health savings account (HSA).....	1
• Making contributions to your HSA.....	4
• Services covered by your medical plan.....	6
• Managing money in your HSA.....	7
• Tax benefits.....	8
Choosing health care providers.....	8
Prescription drug coverage .....	8
What if I have questions?.....	9
Your privacy .....	10

### Health savings account (HSA)

#### Q. What is a health savings account (HSA)?

A. An HSA is a special tax-sheltered savings account used with medical plans called consumer-driven health plans (CDHPs). By law, to open or contribute to an HSA, the medical plan must be a qualified “high-deductible health plan.” This means the deductible is higher than a traditional medical plan’s deductible. You can use the money in your HSA to help pay your deductible, your coinsurance and other qualified in-network or out-of-network expenses. You can also save money in your health savings account for future health care costs. The account grows with interest. And you have investment options after your account reaches a minimum balance of \$1,000. The HSA belongs to you and the money in the account is yours to keep, even if you leave your employer.

#### Q. How is my HSA funded?

A. Your HSA is funded by your own pre-tax contributions, up to a certain annual limit. You may also contribute money to your HSA after taxes are taken out. Others (including your employer) may contribute to your account as well. The total of all contributions cannot be more than the maximums defined by the U.S. Treasury and the Internal Revenue Service (IRS). (See the question below: How much can I contribute to my HSA? for details.)

#### Q. Who can open an HSA?

A. To be eligible, you must meet the following criteria:

- You must be covered by an HSA-compatible health plan, such as the City of Salem & Salem City Schools HDHP-HSA with HSA plan, and you cannot be covered by any other medical plan that is not an HSA-compatible health plan. This would include being enrolled in your spouse’s plan as secondary coverage. Federal law requires minimum deductible levels for individual and family coverage for HSA-compatible health plans.



- You must be enrolled in the plan on the first day of the month; otherwise, your eligibility to make contributions to your HSA begins the first day of the following month. You may make the maximum annual HSA contribution for the year regardless of the month you become eligible. You must remain enrolled in the HSA-compatible health plan for 12 months of the following tax year.
- You must not be enrolled in Medicare.
- If you are a veteran, you may not have received veterans' benefits within the last three months.
- You must not be on active military status.
- You must not be eligible to be claimed as a dependent on another person's tax return.

The IRS has specific rules on who can open an HSA. See those rules in [IRS Publication 969](#).<sup>1</sup>

**Q. Can I enroll in the City of Salem & Salem City Schools HDHP-HSA with HSA if my spouse is on Medicare?**

- A. Yes, as long as you are not enrolled in Medicare and you meet the IRS eligibility requirements for an HSA, you can enroll in the City of Salem & Salem City Schools HDHP-HSA with HSA. You can contribute to an HSA and you may choose to cover your spouse on your plan and use the funds in your HSA to pay for qualified medical expenses for you and your spouse on Medicare.

**Q. My spouse is enrolled in Medicare. Can he or she also be enrolled as a dependent on the City of Salem & Salem City Schools HDHP-HSA with HSA?**

- A. Yes, but your spouse cannot open an HSA account in his or her own name because he or she is on Medicare. You may use the funds in your HSA to pay for qualified medical expenses for you and your spouse on Medicare.

**Q. If my spouse is on Medicare and I am not on Medicare, how much can I contribute to an HSA?**

- A. If you are enrolled in family coverage (two or more people), the IRS will only allow you to set up an HSA. You may contribute up to \$6,750 in 2016. You can use the HSA funds to pay for your spouse's out-of-pocket expenses, even if he or she is on Medicare.

**Q. I am enrolled in Medicare Part A as I continue to work. Can I enroll in the City of Salem & Salem City Schools HDHP-HSA with HSA?**

- A. Yes, you can enroll in the City of Salem & Salem City Schools HDHP-HSA with HSA if you have Medicare Part A. However, you will not be eligible to make contributions to the HSA.

**Q. Who can use the money in an HSA?**

- A. The money can be used for qualified health care costs for you, your spouse or any IRS-qualified dependent who you claim on your income taxes, whether or not he or she is covered on your health care plan. Talk with a tax advisor to find out if these rules apply to your tax situation. You can also go to [irs.gov](http://irs.gov) to find out who qualifies as a dependent.

You may not use the HSA funds for health care costs for a domestic partner or child who does not qualify as your tax dependent. If your domestic partner is covered by your City of Salem & Salem City Schools HDHP-HSA with HSA plan, he or she can set up his or her own HSA at a financial company that manages HSA plans.

Payments for a dependent who doesn't meet the definition of "tax dependent" may be considered nonqualified costs. This means you may have to pay taxes and penalties for these payments. For more details about eligible expenses and dependents for HSAs, see [IRS Publication 969](#).<sup>1</sup> Keep in mind that this document changes regularly and you should check with your tax adviser if you have questions.

**Q. I am enrolled in the City of Salem & Salem City Schools HDHP-HSA with HSA. Can I continue to contribute to my spouse's HSA and use his or her bank?**

- A. You and your spouse can continue to make contributions to his or her HSA, but you cannot contribute more than the IRS family contribution maximum between both HSA accounts. For 2016, the family contribution maximum is \$6,750.

**Q. My child is under 26 but I no longer claim him or her on my taxes. Can I cover him or her on the City of Salem & Salem City Schools HDHP-HSA with HSA?**

A. The IRS has specific rules about covering a child. See [\*\*IRS Publication 969\*\*](#).<sup>1</sup> You can cover dependents under age 26 in the City of Salem & Salem City Schools HDHP-HSA with HSA, but you can't use your HSA account for their expenses unless they meet the following requirements:

- Account holder must be able to claim the child on his or her tax return.
- Your child is under age 19 or under age 24 if a full-time student, or totally and permanently disabled.

Dependents who do not qualify to receive funds from your HSA may qualify to open their own HSA and could be permitted to contribute up to the family maximum (for 2016, this is \$6,750). They can contact a financial institution to discuss how to set up a separate HSA.

**Q. My child is under age 26 and married. Can I cover him or her on my medical plan?**

A. Yes, eligible dependents can be covered to the age of 26. Under health care reform, this applies to all dependent children up to age 26, regardless of student, employment, residential or marital status.

- The health care reform law expanded the definition of eligible dependents to age 26 for medical plan coverage, FSAs and health reimbursement accounts (HRAs).
- The law did not expand the definition of eligible dependent to age 26 for HSA expenses. Therefore, employees can use HSA funds tax-free only for eligible expenses of family members who meet the definition of a "tax dependent" in the Internal Revenue Code. Please refer to the previous Q&A.
- Disbursements for children who don't meet this stricter definition may be considered nonqualified expenses, which are subject to tax and penalties. That means you'll pay a penalty plus taxes if you use the pretax dollars from your HSA to pay health expenses for your older covered dependent if he or she does not meet the IRS definition of a tax dependent.
- Please refer to the [\*\*IRS Publication 969\*\*](#)<sup>1</sup> for more information or speak with your tax adviser.

**Q. I do not have custody of my two children. I do not claim them on my tax return. Can I use funds in my HSA to pay for their qualified health care costs?**

A. For purposes of medical and dental expense deductions, a child of divorced or separated parents can be treated as a dependent of both parents. Each parent can include the health care costs he or she pays for the child, even if the other parent claims the child's dependency exemption, if:

- The child is in the custody of one or both parents for more than half the year.
- The child receives more than half of his or her support during the year from his or her parents.
- The child's parents:
  - Are legally divorced or separated.
  - Are separated under a written agreement.
  - Lived apart at all times during the last six months of the year.

This does not apply if the child's exemption is being claimed under a multiple support agreement.

To find out more about covering children and children of divorced or separated parents, please see [\*\*IRS Publication 969\*\*](#)<sup>1</sup> and talk with a tax adviser.

**Q. If I am covering a child who is age 23 and I cannot claim him or her as a tax dependent, what is my maximum contribution to an HSA on a pretax basis?**

A. If the child cannot be claimed as a tax dependent, the child is eligible to establish his or her own HSA and can contribute up to the family maximum (\$6,750 for 2016). The employee also can contribute up to the family maximum in his or her HSA in this example.

**Q. I have an HSA with another bank. Can I keep it? Do I have to open an account with your partner bank?**

A. You can keep the HSA account you have. But, all contributions from your paycheck will only go to your employer-sponsored HSA. Also, you will have to pay any bank charges for your other HSA.

**Q. What is the difference between an HSA and a health care flexible spending account (FSA)?**

- A. Both HSAs and FSAs can be funded with pre-tax dollars and be used to pay for medical expenses. However, HSA balances can roll over from year to year, while FSA money is forfeited if it is not spent during a 12-month period. And, if you leave your employer, your HSA dollars are yours to keep. FSA dollars are forfeited.

**Q. Can I have an HSA and an FSA?**

- A. Yes, you are eligible to have both an HSA and an FSA only if the FSA has been defined as either a:
- **Limited/Special Purpose FSA**, which may be limited to dental or vision services.
  - **Limited Purpose High-Deductible FSA**, which also allows for dental or vision services, as well as paying for coinsurance under the traditional health component of the plan, after meeting the deductible.

**Making contributions to your HSA**

**Q. How do I make contributions to my HSA?**

- A. If your employer allows it, the easiest way is through pretax payroll deductions. However, you may also contribute directly to your HSA after taxes. To make after-tax contributions, call your HSA financial company or go online to the financial company's member website and set up an electronic fund transfer from your personal bank account.

**Q. How much can I contribute to my HSA?**

- A. The annual contribution maximum in 2016 is \$3,350 for individual coverage and \$6,750 for family coverage. The maximums are set by the U.S. Treasury and the IRS. Those maximums may go up every year for inflation. Check [irs.gov](http://irs.gov) for the most current maximum amounts.

**Q. Can I ever contribute more than the annual limit?**

- A. Yes, people aged 55 and older who are not enrolled in Medicare can contribute an extra \$1,000 above the regular limits. This is called a "catch-up contribution." These individuals can make catch-up contributions each year until they enroll in Medicare.

Only the account holder can make catch-up contributions. The contribution amounts allowed are subject to proration if you are enrolled in the plan less than 12 months or under other circumstances. Catch-up contributions can be made in the same way your regular contributions are made.

**Q: If I am 55 and older and my spouse is too, can we both make catch-up contributions?**

- A. If only one spouse has an HSA in his or her name, only that spouse can make a catch-up contribution. If both of you want to make catch-up contributions when you are age 55 or older, you must establish separate HSA accounts. Please note the contribution combined cannot be more than the IRS family contribution maximum.

**Q. What if I contribute too much to my account during a year and go over the annual maximum allowed?**

- A. If you contribute too much to your account, IRS rules require that you pay regular income tax, plus a tax penalty on the amount you went over. If you realize you've contributed too much before you file your taxes, you may choose to submit a form showing these contributions to the HSA financial company to remove those excess funds. Different rules apply if you contributed too much because you left the plan during the year. See the question *What if I end my coverage before the end of the year?* to find out more.

**Q. What if I end my coverage before the end of the year?**

- A. You take that money with you wherever you go. The HSA is in your name and it's your account. If you're on Medicare or go to another employer who doesn't have a qualified high-deductible health plan, you can still use your HSA money to pay for copays and qualified medical expenses. However, you won't be able to continue to make contributions to your HSA unless you continue to participate in an HSA-compatible plan.

If you leave during the year and do not enroll in another HSA-compatible plan, the annual contribution maximum is prorated. This is based on the number of months that you were enrolled in an HSA-compatible plan. If you fund your account for the entire year, then leave the plan and do not join another HSA-compatible health plan, you will need to withdraw the excess funds before the end of the tax year. You'll have to treat these funds as taxable income if you have over-funded the account. If you don't, you may have to pay tax penalties.

For example, let's say Mary was enrolled in the City of Salem & Salem City Schools HDHP-HSA with HSA and changes jobs on July 1, 2016, and is no longer eligible to contribute to her HSA. She would figure out her health savings maximum contribution amount for that year this way:

$$\$3,350 \times 6 \text{ months} / 12 \text{ months} = \$1,675$$

You can contact your HSA financial company if you have questions about your account.

**Q. What if my spouse has an HSA, too?**

A. The chart below explains different situations:

If your spouse:	And you have:	Then, the IRS:
Has PPO (preferred provider organization) self + children coverage.	HDHP (high-deductible health plan) self-only coverage.	Treats you as having single coverage and only you may set up an HSA (health savings account). You may contribute up to \$3,350.
Has HDHP self-only coverage with a \$1,500 deductible.	HDHP self + child coverage with a \$3,000 deductible.	Treats you both as having family coverage, and combined you may contribute up to \$6,750 to an HSA.
Has HDHP self + family coverage with a \$3,000 deductible.	HDHP self + spouse coverage with a \$3,000 deductible.	Treats you both as having family coverage, and combined you may contribute up to \$6,750 to an HSA.
Is enrolled in Medicare.	HDHP self + family coverage only.	Will only allow you to set up an HSA. You may contribute up to \$6,750.

**Q. Does tax filing status (joint vs. separate with my spouse) affect my HSA contribution?**

A. Tax filing status does not affect your contribution. The IRS requirements simply refer to eligible expenses for the "spouse" — they do not include requirements for filing jointly or separately. However, the IRS indicates that children must be tax dependents. **IRS Publication 969<sup>1</sup>** has more details. See the question *I do not have custody of my two children* to learn more.

**Q. Can I use the HSA account for eligible expenses for my spouse even if we file our taxes separately?**

A. Yes, the IRS requirements simply refer to eligible expenses for the "spouse" — they do not include requirements for filing jointly or separately. However, the IRS indicates that children must be tax dependents. IRS Publication 9691 has more details.

**Q. I am going to enroll in the City of Salem & Salem City Schools HDHP-HSA with HSA. What happens if my spouse chooses coverage under a health care FSA?**

A. Usually, a health care FSA covers the expenses of the participant and the participant's spouse and dependents. If your spouse has a health care FSA, most likely your health care costs are covered under your spouse's FSA. If so, then you won't be able to make contributions to your HSA.

There are exceptions to this rule. For example, if your spouse's FSA is a limited-purpose FSA that only covers dental and vision costs.

**Q. Can I use my HSA to pay for medical expenses before I set up my account?**

A. No. You cannot be reimbursed for qualified medical expenses before the date your HSA account is established.

**Q. What happens if I have a medical expense early in the year and there isn't enough money in my HSA to cover my out-of-pocket costs?**

A. The HSA works like a bank account. You can only spend what is in the account. However, you can start the reimbursement process for any services incurred after you enrolled in the HSA when you have more funds in your account.

**Q. What counts toward my out-of-pocket maximum?**

- A. The out-of-pocket maximum adds together your deductible and the percentage you shared in the cost for covered expenses (your coinsurance or portion of the cost). Once you reach the maximum out-of-pocket, the plan pays covered expenses at 100% for the rest of the year.

It's very important to understand that if the provider's charge is more than our maximum allowed amount for out-of-network services, you will be responsible for paying the difference. Out-of-network providers can bill you for balances above the amount your plan pays, even if you've paid your out-of-pocket maximum.

**Q. Are deductibles included in the out-of-pocket maximum for the City of Salem & Salem City Schools HDHP-HSA with HSA?**

- A. Yes, deductibles and coinsurance for your medical and pharmacy costs are included in the out-of-pocket maximum. This includes your prescription drug costs.

**Q. Once I reach my out-of-pocket maximum, do I still have to pay for office visits and prescriptions?**

- A. No. Once you meet your out-of-pocket maximum, the plan pays 100% for covered expenses. If you use out-of-network providers they can bill you for the amount above what we allow and this will be your responsibility to pay.

**Q. Are dental and vision care considered qualified medical expenses for purposes of a health savings account?**

- A. Yes, many dental, orthodontia and eye care expenses are considered qualified medical expenses. However, cosmetic procedures, like cosmetic dentistry, would not be considered a qualified medical expense. For a detailed list, please see [IRS Publication 502](#).<sup>2</sup>

**Q. What if I have money left in my HSA at the end of each plan year?**

- A. Whatever you don't spend is yours to keep and save year after year. Your HSA can help you pay for future health care costs.

**Q. How can I find out more about HSA regulations?**

- A. Go to the U.S. Treasury website at [treasury.gov](https://www.treasury.gov) and type HSA in the search box. You may also read [IRS Publication 969](#).<sup>1</sup>

**Services covered by your medical plan**

**Q. What is traditional health coverage?**

- A. Once you meet your deductible in a City of Salem & Salem City Schools HDHP-HSA with HSA plan, the plan works like a preferred provider organization (PPO) plan. You pay coinsurance (a percentage of what the provider can charge) when you go to a network provider. You'll pay more if you go to a provider who is not in the network. Check your plan summary to find out more about coinsurance.

**Q. What services does the City of Salem & Salem City Schools HDHP-HSA with HSA plan cover?**

- A. It covers services that are usually covered by a typical health plan. That includes things like office visits, prescription drugs and major surgeries. Check your plan summary to see some of the services covered by your plan.

You can use your HSA to pay for qualified health care costs not covered by your plan. For a list of qualified medical expenses, see [IRS Publication 502](#).<sup>2</sup>

**Q. What about preventive care services like mammograms and checkups?**

- A. The medical plans cover preventive care services like checkups, vaccines and mammograms at 100% when you use a provider in the network. You won't have to pay anything out of your own pocket when you get care from a network provider. You may choose to use your HSA funds to cover these costs.

**Q. How do I know what is considered preventive care?**

- A. Our medical plans cover preventive care services like checkups, vaccines and mammograms at 100% when you see a network provider. Your Summary Benefit Description shows which services are covered by your plan. In addition, this brochure gives you a general understanding of what is covered under

preventive services.

## Managing the money in your HSA

### Q. Who holds the money in my HSA?

A. A qualified financial institution holds it and handles those records. If your employer selects an Anthem partner bank, we will handle all of the enrollment administration for you.

### Q. How do I find out my HSA balance?

A. It's easy. First register at anthem.com after you get your medical ID card. Then, log in and go to the bank website. There, you can see your account balance, transactions and manage your personal information online.

### Q. Will I have to register to use the site the first time I log in to the bank website through anthem.com?

A. Yes, the first time you go to the HSA bank website from anthem.com, you will need to set up a username and password. After you do that, you will be able to use the banking site member website through anthem.com. Also, you will be able to use the bank website username and password to access your information directly through their website and through their mobile application.

### Q. How do I access the money in my HSA?

A. You will receive a debit card to use to pay for eligible expenses when funds are available. You also can make payments online at the HSA bank website. You can pay the provider directly or get reimbursed for an eligible cost online.

### Q. Will my HSA earn interest?

A. Yes. The HSA is an interest-bearing account.

### Q. Can I invest my HSA?

A. Yes. You'll need to have at least \$1,000 in your HSA before you can invest it. You can invest in certain mutual funds after you reach the \$1,000 minimum balance in your account.

### Q. Are the interest and investment earnings in my HSA tax-free?

A. Yes, when the funds are distributed and used for qualified health care costs. Interest and investment earnings grow tax-deferred in the account. That means you'll only be taxed if funds are withdrawn for non-health care costs.

### Q. Are any administrative fees charged to my HSA?

A. Yes, you'll have to pay banking fees, such as overdraft charges or charges for debit cards to replace lost ones. When you enroll in the program, you will get information about the account.

### Q. Is there a time restriction on when I may use the funds in the account?

A. No. Once funds are put into the HSA, they may be used at any time in the future for qualified health care costs.

### Q. If I leave the medical plan, what happens to my HSA?

A. You own the HSA; the money is yours to keep. You may choose to keep the funds in your account or roll the funds into a different account. If you leave the funds in your account, you will have to pay fees to keep it. If you retire and are insured by Medicare, change to a health plan that is not an HSA-compatible plan or go to another employer that doesn't offer an HSA-compatible plan, you can still use your HSA to pay for out-of-pocket qualified health care costs. But you won't be able to continue to make contributions to your HSA.

### Q. Can I roll over funds from my HSA to another HSA if I leave the program?

A. Yes. Contact your new HSA administrator for help with the rollover process.

### Q. What if I use HSA funds to pay for nonqualified health care costs?

A. If you realize you've used HSA funds for nonqualified health care costs before you file your taxes, you can fill out a form showing these contributions, along with a check to put the funds back in your HSA. If you've filed your taxes and did not return the funds, the amount you spent on the nonqualified expense will be considered part of your taxable income. You will also owe a 20% penalty on that amount if you are under age 65.

**Q. Do I have to use funds from my HSA to pay for health care costs?**

A. No. You may pay out of pocket with after-tax dollars and let your HSA balance grow tax-free.

## Tax benefits

**Q. What are the tax benefits of an HSA?**

- A. There are several benefits:
- Contributions to the account are (federal) tax-deferred or tax-advantaged.
  - Any investment and interest earned in your account are (federal) tax-deferred.
  - Withdrawals from the account for qualified health care costs are (federal) tax-free.
  - Depending on the state where you live, you may save on your state tax as well.

## Choosing health care providers

**Q. What is the difference between in-network and out-of-network providers?**

A. Network providers are doctors, hospitals, facilities and other health care providers who are part of the network. That means they have a contract with us and will accept the amount we allow as payment in full for certain covered services. This large network includes many providers and specialists so you find the care you need.

You can even find network care when you travel across the country with the BlueCard® PPO program, which is included with your plan. Just call **1-800-810-BLUE** if you need care away from home.

Out-of-network providers do not have a contract with us and have not agreed to accept the amount we allow as payment in full for specific covered services. This means out-of-network providers may charge more for services than what the network providers agree to accept. If you see an out-of-network provider, you'll pay a higher coinsurance, plus any provider charges above what we allow.

**Q. How do I know if my doctor is in the network?**

A. You can search the provider network by going to [anthem.com](http://anthem.com) and selecting **Find a Doctor**. Follow the steps and select your plan. If you need more help, call the Member Services number on the back of your ID card.

**Q. If my doctor isn't in the network, can I still use his or her services?**A. You can go to any doctor you choose. And you don't need a referral to see a specialist. However, you'll save money when you go to a network doctor. Also, if you see an out-of-network doctor, you may have to file a claim yourself. You can download a claim form at [anthem.com](http://anthem.com).

**Q. Can I go to any doctor or hospital when I travel away from home?**

A. Yes. Many providers throughout the country are part of the BlueCard PPO® program. To find a network doctor or hospital when you travel, call **1-800-810-BLUE**. However, if you see an out-of-network provider, you may end up paying more out of pocket.

**Q. If I need to file a claim, how do I get reimbursed?**

A. In most cases, you won't need to file a claim if you go to a network provider. If you go to an out-of-network provider, you might have to file the claim. If so, send your claim to us for reimbursement. You can download a claim form at [anthem.com](http://anthem.com).

## Prescription drug coverage

**Q. Does the HSA plan cover prescription drugs?**

A. Yes. Show your ID card when you go to your pharmacy. If you have funds in your HSA, you can choose to use your HSA debit card for your share of the cost at the pharmacy. You also can use your HSA debit card for your cost when you use the home delivery pharmacy service if you have funds available.

If you have used all of the funds in your HSA — or choose not to use these funds and save them for future use — you will have to pay out of pocket until you meet your annual deductible before the traditional health coverage part of the plan begins. Then, you will pay any coinsurance for your prescription drugs. Check your plan summary to find out more about your prescription drug benefits.

**Q. Is there a preferred drug list for the HSA plan?**

- A. No, you don't have to use medications from a preferred drug list.

**Q. Do I need to get preauthorization for any drugs?**

- A. Some medications are not covered unless you first get approval through a coverage review process. To save you time and help avoid any confusion, check to see if your medication requires coverage review (prior authorization) by calling Member Services at the number on your medical plan ID card.

Some medications may be covered, but they may have limits (like only for a certain amount or for certain uses and lengths of time) unless you get approval through a coverage review. Before the medication may be covered under your plan, we will ask your doctor for more information to make a decision.

**Q. Do my prescription costs apply to my out-of-pocket maximum or my medical deductible?**

- A. Yes, prescription drug costs apply to your annual deductible and the medical annual out-of-pocket maximum. Once you meet your deductible, you begin to pay the copay or coinsurance.

**Q. How do I submit prescriptions to the home delivery pharmacy?**

- A. Home delivery pharmacy is an easy and cost-effective way for you to get a medication for an ongoing condition. We encourage you to use the member website to download the most up-to-date home delivery order form, which will help speed up the processing of the home delivery prescription order. You can access and download the Express Scripts prescription order form by logging in to the anthem.com member website and selecting Pharmacy, which will take you to the Express Scripts website. Prescription order forms for home delivery are available to download from the site. You also will get a printed order form with each order that's filled by the Express Scripts pharmacy.

**Q. Do I need to use a particular pharmacy for specialty drugs?**

- A. Please contact Member Services to find out more about specialty drug coverage.

**Q. How do I get the most out of my pharmacy benefits?**

- A. There are a few key steps to take to get the most out of your pharmacy benefits:
- Show your ID card when you drop off your prescriptions.
  - Have your prescriptions filled at a participating pharmacy.
  - Ask for generic drugs to lower your out-of-pocket cost.
  - When possible, use the home delivery pharmacy for your prescriptions.

## What if I have questions?

**Q. How does the money I contribute to my HSA help me save on taxes?**

- A. Any money you contribute to your HSA is considered (federal) tax-deductible. That means it's not counted as taxable income for the year. So, if you put \$1,000 into your HSA, your adjusted gross income for the year is lowered by \$1,000, which could save what you owe for taxes, depending on your tax status.

**Q. What should I do with the receipts for services I had?**

- A. You should keep them. Since you own the HSA, you are responsible for giving documentation to the IRS, if you ever need to, for the expenses charged to your HSA. You can upload your receipts to the bank's member website and save them to your HSA member website. You can do this online or through your mobile phone.

**Q. Are there any special instructions for filing my taxes?**

- A. Yes. You will have to complete a *Form 8889* to report your HSA contributions and distributions when you file your taxes. Information from *Form 1099-SA* mailed to you by financial institution by early February shows annual distributions. You can find *Form 8889* and instructions at [irs.gov](https://www.irs.gov).

You'll receive *Form 5498-SA* from the HSA bank each May. It's for your information only. You don't need to file it with your tax return. And you'll need to keep track of your receipts for anything you pay for from your account in case you need to give documentation to the IRS to show you used any HSA funds on qualified health care costs. Please talk with a tax adviser to make sure you file your taxes correctly.

**Q. Who do I contact if I have questions about my plan?**

A. Please contact us with any questions you have about your plan. You can reach Member Services by calling the number on the back of your ID card or visiting [anthem.com](http://anthem.com). You and your family members should receive your ID cards by your effective date of coverage. If you don't receive them, or if you misplace one, please contact us.

## Your privacy

**Q. Is your website secure?**

A. Yes. Our customer-only website is secure and password-protected. Your personal information is kept safe using the highest encryption level available.

**Q. What is your privacy policy?**

A. You can read the Privacy Policy anytime at [anthem.com](http://anthem.com).



The information included does not constitute legal, tax, or benefit plan design advice. We strongly encourage you to consult with a tax adviser before establishing a health savings account. Any health savings account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

1 <http://www.irs.gov/pub/irs-pdf/p969.pdf>

2 <http://www.irs.gov/pub/irs-pdf/p502.pdf>



# Lumenos® with HSA Plan Summary

The Lumenos with HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way. And to help offset your out-of-pocket health expenses.

## Your Lumenos with HSA Plan

### First - Use your HSA to pay for covered services:

#### Health Savings Account

With the Lumenos with Health Savings Account (HSA), you can **contribute pre-tax dollars to your HSA**. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

### Annual Contribution Maximum to Your HSA

The annual contribution maximum set by the U.S. Treasury and IRS:

**2016:** \$3,350 individual coverage \$6,750 family coverage  
**2017:** \$3,400 individual coverage \$6,750 family coverage

Note: These limits apply to all combined contributions from any source. Rollover funds are not subject to these limits.

### Plus - To help you stay healthy, use:

#### Preventive Care

100% coverage for nationally recommended services.

### Preventive Care

No out-of-pocket costs for you as long as you receive your preventive care from a network provider. If you choose to go to an out-of-network provider, your deductible or traditional health coverage benefits will apply.

### Then -

#### Your Deductible

The deductible is the annual amount you pay – using your HSA or out-of-pocket – before you reach the traditional health coverage portion of the plan.

### Annual Calendar Year Deductible Responsibility

\$3,000 individual coverage  
\$6,000 family coverage (\$3,000 individual level)

Your **benefit period** is a calendar year. A **calendar year** means your benefit period runs from January through December.

### If needed -

#### Traditional Health Coverage

Similar to a PPO or HMO, after you meet your deductible, you pay coinsurance (a percentage of the provider's charges) or a copay when you visit a network provider. You'll pay more if you visit an out-of-network provider. Your traditional health coverage begins:

- 1) Once any family member reaches the individual level deductible (within the annual deductible), that family member's future expenses will be eligible for traditional health coverage.
- 2) The remaining family members must satisfy the remainder of the annual deductible before traditional health coverage begins.

### Traditional Health Coverage

After your deductible, the plan pays:

100% for network providers	80% for out-of-network providers
100% for network pharmacies <sup>1</sup>	same as network pharmacies <sup>1</sup>

After your deductible, your coinsurance or copay responsibility is:

0% for network providers	20% for out-of-network providers
--------------------------	----------------------------------

Prescription drugs, after deductible:

Retail <sup>2</sup> : \$10/\$30/\$50 or 20%/\$50 or 20% up to 30 day fill	same as network pharmacies
Mail <sup>2</sup> : \$10/\$60/\$150 or 20%/N/A	up to 90 day fill n/a

<sup>1</sup>Plan pays percentage after member tier copay/coinsurance.

<sup>2</sup>For tier 3 & 4 drugs, copay or coinsurance whichever is greater up to \$200 per script retail and \$400 per script mail.

At retail pharmacies you may get up to a 30 day supply per fill.

90 day Retail Maintenance allows up to a 90 day supply of maintenance medications for 3x the 30 day retail cost share or copay.

### Additional protection:

For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the **plan pays 100% of the cost for covered services** for the remainder of the plan year.

### Annual Calendar Year Out-of-Pocket Maximum

Network Providers	Out-of-Network Providers
\$4,000 individual coverage	\$6,000 individual coverage
\$8,000 family coverage	\$12,000 family coverage

Your annual out-of-pocket maximum consists of your annual deductible and your copay/coinsurance amounts.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

## Overview of Covered Preventive Services

### Preventive Care

Anthem's Lumenos with HSA plan covers preventive services<sup>1</sup> recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to help prevent avoidable premature injury, illness and death.

All preventive services received from a network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes — for example, a colonoscopy when symptoms are present — the appropriate plan deductible and coinsurance will apply and available account funds may be used to cover costs.

The following is an overview of the types of preventive services covered:

#### Child Preventive Care

**Office Visits** for preventive services  
**Screening Tests** for vision, hearing, and lead exposure. Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.  
**Immunizations:**  
 Hepatitis A  
 Hepatitis B  
 Diphtheria, Tetanus, Pertussis (DtaP)  
 Varicella (chicken pox)  
 Influenza – flu shot  
 Pneumococcal Conjugate (pneumonia)  
 Human Papilloma Virus (HPV) – cervical cancer  
 H. Influenza type b  
 Polio  
 Measles, Mumps, Rubella (MMR)

#### Adult Preventive Care

**Office Visits** for preventive services  
**Screening Tests** for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.  
**Immunizations:**  
 Hepatitis A  
 Hepatitis B  
 Diphtheria, Tetanus, Pertussis (DtaP)  
 Varicella (chicken pox)  
 Influenza – flu shot  
 Pneumococcal Conjugate (pneumonia)  
 Human Papilloma Virus (HPV) – cervical cancer

## Summary of Exclusions or Limitations

Some covered services may have limitations or other restrictions.<sup>2</sup> With Anthem's Lumenos with HSA plan, the following services are limited:

Annual routine vision exam \$15; not subject to deductible.  
 Skilled nursing facility services limited to 100 days per benefit period.  
 Home health care services limited to 100 visits per benefit period.  
 Physical and occupational therapy services limited to a combined 30 visits per benefit period.<sup>3</sup>  
 Speech therapy services limited to 30 visits per benefit period.<sup>3</sup>  
 Spinal manipulations and other manual medical intervention visits limited to 30 visits per benefit period.  
 Early intervention services are unlimited per member per year up to age 3.  
 Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder is unlimited per member per benefit period.  
 Private duty nursing is limited to 16 hours per member per calendar year.  
 Wigs limited to 1 wig per member per year.  
 Your Lumenos HSA also includes **No Lifetime Maximum.**

<sup>1</sup> Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.  
<sup>2</sup> Additional limitations and exclusions may apply. For a complete list of exclusions and limitations, please refer to your Certificate of Coverage. Some covered services may require pre-approval.  
<sup>3</sup> Speech, physical and occupational therapies are unlimited for Early Intervention and Autism Spectrum Disorder

**Please note:** This summary is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefit levels may vary. The information included does not constitute legal, tax, or benefit plan design advice. Anthem strongly encourages consultation with a tax advisor before establishing a Health Savings Account. Any Health Savings Account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.  
 Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM is registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

# Your Lumenos HSA prescription drug plan

## 30-Day Retail Pharmacy Network

Our network includes more than 69,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

## Retail 90 Pharmacy

Retail 90\*\* is a unique network that offers more ways for you to get the maintenance medications you need. Maintenance medications are drugs taken on an ongoing basis for conditions such as asthma, diabetes or high cholesterol. Through Retail 90, you can choose to get a 90-day supply of medications from a participating retail pharmacy.

\*\*Approximately 98% of the pharmacies in our network participate in the Retail 90 program. Be sure to check with your local pharmacy to verify their participation status prior to placing your 90 day retail prescription order.

To make sure your pharmacy's in our network, visit [anthem.com](http://anthem.com) and select Find a Doctor which will take you to the list of providers, pharmacies and hospitals who participate in our network.

## Home Delivery Pharmacy

Members needing maintenance medications also have the option to use our Home Delivery Pharmacy service. Our preferred Home Delivery Pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- 90-day maintenance medications for less cost than if you purchased them at a retail location
- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

## Ordering refills

With home delivery, you don't have to worry about running out of medication. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

## Specialty Pharmacy

Accredo, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. Most specialty medications are limited up to a 30 day supply regardless of whether they are retail or mail (Transplant and HIV/AIDS medications are covered up to a 90 day supply). They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn's Disease
- Growth Hormone
- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Accredo CareLogic® programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication and side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. Nurses, pharmacists and patient care

# Your prescription drug plan (continued)

advocates work together to help improve your care. Their goal is to help you get the best results from your treatments. Call 800-870-6419 to learn about how CareLogic can help you better manage your health condition.

## Drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs. We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit [anthem.com](http://anthem.com). Click on "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the Drug List on this page. If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

## Preferred Generics

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of a brand drug – but usually at a lower cost.

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

## Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

## Step Therapy

Step Therapy may be required for certain drugs. Step Therapy refers to the process in which you may be required to use one type of medication before benefits are available for another. Step Therapy helps you and your doctor choose drugs that are safe, affordable and right for you. When your doctor prescribes a drug that requires step therapy, a message is sent to your pharmacy. This lets the pharmacist know you must first try a different, similar drug that's covered by your plan. The pharmacist will call your doctor to get a prescription for the new drug.

## Quantity Limit

Taking too much medicine or using it too often isn't safe. And it may even drive up your health care costs. That's why your plan may limit the amount of medicine that's covered for a certain length of time. For example, a drug may have a limit of 30 pills per 30 days. If you refill a prescription too soon or your doctor prescribes an amount that's higher than usual, your pharmacist will tell you.

The Drug List also includes this information. To view it, visit [anthem.com](http://anthem.com). Click on "Customer Care" in the top-right corner. Select your state, and then click on "Download Forms." You'll find the Drug List on this page.

# Your prescription drug plan (continued)

*Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.*

*Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliates, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association.®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.*

*This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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.

# Take care of yourself. Use your preventive care benefits.



And Its Affiliate HealthKeepers, Inc.

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.<sup>1</sup> When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

## Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

## Child preventive care

### Preventive physical exams

#### Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24, with fair skin, about ways to lower their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening<sup>2</sup> when done as part of a preventive care visit

#### Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

## Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met<sup>3</sup>
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)<sup>4,5</sup>
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening<sup>5</sup>
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV<sup>5</sup>
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

*This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.*

## Adult preventive care

### Preventive physical exams

#### Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision<sup>2</sup>
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years<sup>6</sup>
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

#### Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

## A word about pharmacy items

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age and other specified criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not “need” a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

#### Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old
- Fluoride supplements for children from birth through 6 years old
- Iron supplements for children 6-12 months

#### Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older
- Vitamin D for men and women over 65

#### Women’s preventive drugs and other pharmacy items — age appropriate:

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides<sup>5,7</sup>
- Low dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women 55 years old or younger
- Breast cancer risk-reducing medications following the U.S. Preventive Services Task Force criteria (such as tamoxifen and raloxifene)<sup>6</sup>

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the 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 the 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 Customer Service number on your ID card.

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

3 Check your medical policy for details.

4 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

5 This benefit also applies to those younger than 19.

6 You may be required to get prior authorization for these services.

7 A cost share may apply for other prescription contraceptives, based on your drug benefits.

**WELCOME TO  
BLUE VIEW VISION!**

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what’s covered, your discounts, and much more!



**Blue View Vision<sup>SM</sup>  
Exam Only A15 Plan**

**Your Blue View Vision network**

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision’s network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Sears Optical<sup>SM</sup>, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at the telephone number listed on the back of their ID card with questions about vision benefits or provider locations.

**YOUR BLUE VIEW VISION PLAN AT-A-GLANCE**

**VISION CARE SERVICES**

**Routine eye exam** – once every calendar year

**IN-NETWORK**

\$15 copay

**OUT-OF-NETWORK**

\$30 allowance

**USING YOUR BLUE VIEW VISION PLAN**

Just make an appointment for a comprehensive eye exam with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

**ADDITIONAL SAVINGS ON EYEWEAR AND MORE**

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

**OUT-OF-NETWORK**

If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment at the time of service.

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

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person’s coverage is in force.

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

**anthem.com**

OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY		In-network Member Cost
<b>Retinal Imaging</b>	<ul style="list-style-type: none"> <li>At member's option can be performed at time of eye exam</li> </ul>	Not more than \$39
<b>Eyeglass Frame</b>	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*</li> </ul>	35% off retail price
<b>Eyeglass Lenses</b> Standard plastic material	<ul style="list-style-type: none"> <li>When purchased as part of a complete pair of eyeglasses*:               <ul style="list-style-type: none"> <li>Single Vision \$50</li> <li>Bifocal \$70</li> <li>Trifocal \$105</li> </ul> </li> </ul>	
<b>Eyeglass Lens Options and Upgrades</b> When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	<ul style="list-style-type: none"> <li>UV Coating \$15</li> <li>Tint (Solid and Gradient) \$15</li> <li>Standard Scratch-Resistant Coating \$15</li> <li>Standard Polycarbonate \$40</li> <li>Standard Anti-Reflective Coating \$45</li> <li>Standard Progressive Lenses (add-on to Bifocal) \$65</li> <li>Other Add-Ons and Services 20% off retail price</li> </ul>	
<b>Conventional Contact Lenses</b> (non-disposable type)	<ul style="list-style-type: none"> <li>Discount applies to materials only</li> </ul>	15% off retail price
<b>SOME OF THE ADDITIONAL SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM</b>		
	<ul style="list-style-type: none"> <li>For this and other great offers, <a href="#">login to member services</a>, select discounts, then Vision, Hearing &amp; Dental</li> </ul>	Save \$20 on orders of \$100 or more and get free shipping
<b>LASIK laser vision correction surgery</b>	<ul style="list-style-type: none"> <li>For this offer and more like it, <a href="#">login to member services</a>, select discounts, then Vision, Hearing &amp; Dental</li> </ul>	Discount per eye

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

Cannot be combined with any other offer. Discounts on frames do not apply in the event the manufacturer has imposed a no discount policy on the frame. Discount on frames and special member pricing apply when complete pairs of eyeglasses are purchased together. If purchased separately, members receive a 20% discount off the retail price.

Discounts referenced are not covered benefits under the vision plan and therefore are not included in the member's policy. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. Discounts are subject to change without notice.



# Getting started with home delivery pharmacy

If you take prescribed medicine on a regular basis, you can get up to a 90-day supply mailed right to your door.\*

Here's how to start:

## Step one

### Create your account and print your order form

There are two ways to do this:

- Log on to your health plan's website.
  - Register at your health plan website if you haven't done so.
  - Click **Prescription Benefits** in the *Useful Tools* box.
  - Click **Start a New Prescription**.

This takes you to the Express Scripts<sup>^</sup> website. You can find out how to:

- Print an order form to mail in with your prescription.
- Print a fax form to take to your doctor to fax in your prescription.
- See how much your medicine will cost.

## Step two

### See your doctor for a prescription for a 90-day supply of your medicine

You'll need a 90-day supply prescription for your first home delivery pharmacy order. But you should also ask your doctor to write you another prescription for a 30-day supply. This is so you

can get the 30-day supply filled at your local pharmacy while your first order is being processed.

- Your doctor can give you a prescription to mail in with your order form.
- Or, the doctor can fill out the physician fax form and fax it to the phone number on the form.

If your doctor prescribes a brand-name drug, your plan design may require the home delivery pharmacy to substitute the generic version instead.

## Step three

### Paying for your prescription

You can pay by e-check, check, money order or credit card. You can enroll in e-check payments, have credit cards on file through the website or call the number on your member ID card.



And Its Affiliate HealthKeepers, Inc.

## Step four

### Send us your prescription

You can send us your prescription in two ways:

- **Mail:** Fill out the order form and mail it with the prescription and payment (if you're using a check/money order) to the address listed on the form. Please fill out payment information on the form if you're not using a check/money order.
- **Fax:** Your doctor can complete the physician fax form and fax it to the phone number on the form.

All prescriptions and refills, including those sent in by your doctor, are processed as soon as they are received. Please don't send in your prescription unless you are ready to have it filled.

### Important to know

In most cases, your medicine will be sent to your home within two weeks from the time the home delivery pharmacy gets your order. If you need your medicine sooner, call the number on your ID card to ask for your order to be sent overnight. Please allow three to five days for processing plus the shipping time. You will be charged an additional fee. Your order will be sent through the post office, UPS or FedEx. Please note, with some medicines, you may have to sign to accept delivery.

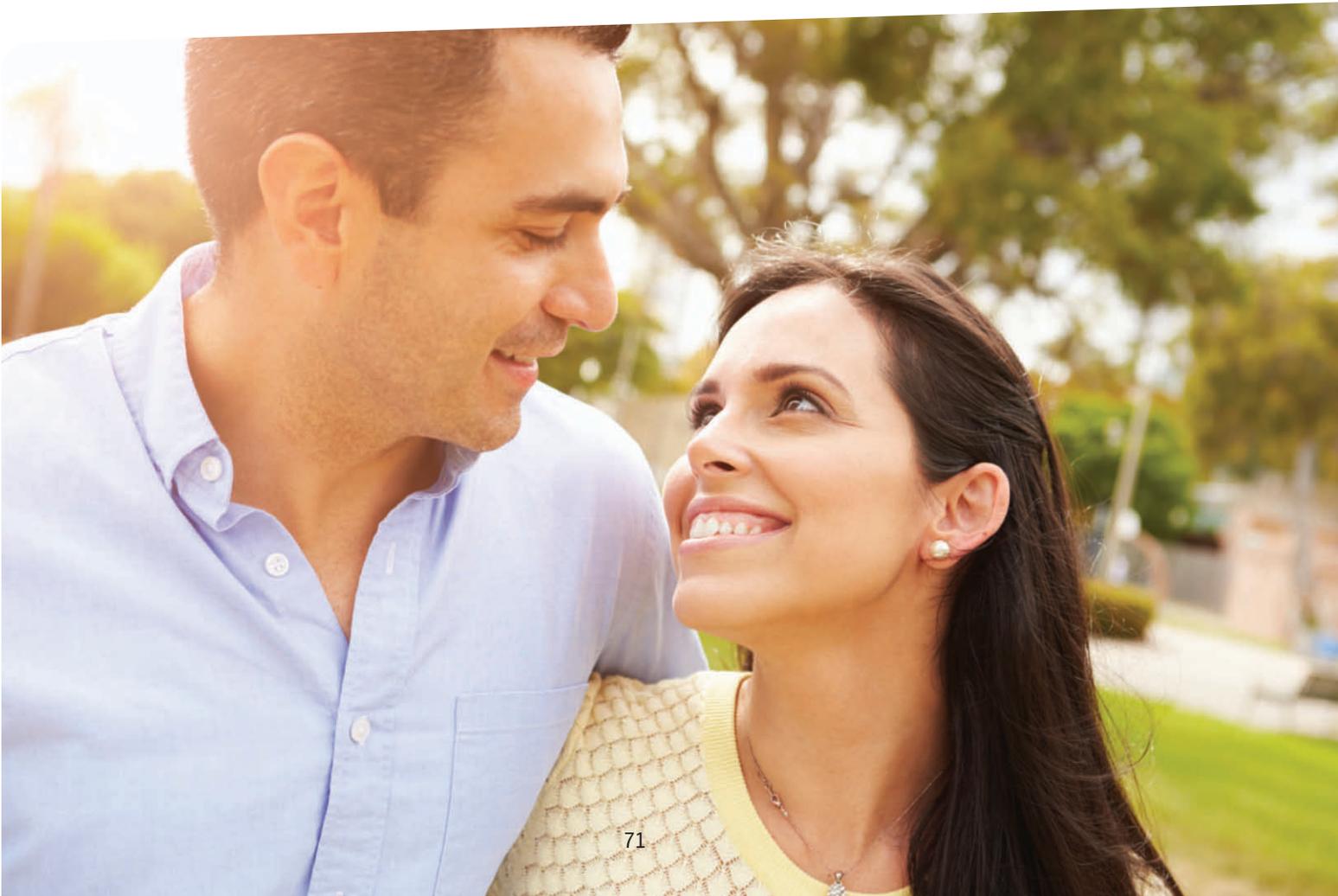
### Need help getting started?

Call the phone number on your ID card. You will be transferred to the home delivery pharmacy. They can help you get started.

\*Based on drug benefit plan design.

\*Express Scripts is a separate company that manages pharmacy services and benefits on behalf of health plan members.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.





# Get the right care with specialty pharmacy

A specialty pharmacy can work with you to help you get the best health results from the drug you take. Be sure to use a network specialty pharmacy because the drug you take may not be covered if you use a pharmacy that's not in the network.

## Treat long-term health issues with the medicines you need

### What is a specialty pharmacy?

If you have a long-term health condition that needs to be treated with complex drugs, our specialty pharmacy program is just what you need. Specialty drugs come in many forms like pills, liquids, injections (shots), infusions or inhalers for people with long-term health problems. These drugs often need special storage and handling, and may be given to you by a doctor or nurse. A specialty pharmacy is for people with health problems such as:

- Asthma
- Bleeding disorders
- Cancer
- Crohn's disease
- Cystic fibrosis
- Growth hormone deficiency
- Hepatitis
- HIV/AIDS
- Iron overload
- Living with a transplant
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)

### We're here to help

You don't have to manage your health condition by yourself. Specialty pharmacy experts can help you get the best results from your treatments.

- Pharmacists can tell you more about your condition, how your drugs work and any side effects. They can also answer urgent drug questions after hours.
- Nurses are available 24/7 to help you stay on track with your medicine. They'll make sure you take it just how the doctor wants. They will also help you with any side effects.
- Care coordinators can help answer questions about insurance, paying for your drugs, getting refills and much more.

Sometimes, a specialty drug is covered through the prescription benefit of a health care plan, while in other cases, a specialty drug will be covered through the medical benefit of a plan.

\* This is not a complete list of conditions treated by specialty drugs.

## Getting started with a specialty drug covered under your pharmacy benefit

Accredo Specialty Pharmacy is the network pharmacy for your specialty drug prescription benefit. Be sure to use Accredo because the drug you take may not be covered if you use a different pharmacy that's not in the network. To see a list of specialty drugs that need to be filled by Accredo, log on at [anthem.com](http://anthem.com) and go to your personalized pharmacy page.

You can easily switch to Accredo by calling the member phone number below, or your doctor can fax a copy of your prescription to Accredo. A care representative will work with you and your doctor to start the steps to fill your specialty drug prescription.

### Accredo Specialty Pharmacy

Member phone number: 1-800-870-6419

Physician fax: 1-800-824-2642

Monday through Friday, 8 a.m. to 11 p.m., ET, and Saturday, 8 a.m. to 5 p.m., ET

After Accredo gets your prescription from the doctor, a care coordinator will call you to set up delivery of your medicine on a day that is good for you. A care coordinator must speak with you to get your approval before sending your drug.

When you sign up with Accredo, you can call the member phone number above if you have questions like how to administer the drug or ways to manage side effects. Nurses and pharmacists are available 24/7 to take your call.

## Getting started with a specialty drug covered under your medical benefit

If you take a specialty drug as an injection or infusion in a doctor's office or hospital outpatient clinic, we may review it for coverage under your medical benefit. Specialty drugs covered through your medical plan can be filled by CVS Specialty Pharmacy.

Your doctor should work with CVS Specialty Pharmacy to start the steps to get you the drug you need. CVS Specialty Pharmacy will call you to talk about your medicine and your cost share. The pharmacy must get your approval before the drug can be sent to you or your doctor's office.

### Questions?

To see personalized pharmacy benefit information, log in at [anthem.com](http://anthem.com). If you haven't signed up on the site yet, you'll have to do that first. After you log in, choose the **Chat with Us** icon to ask questions. You can also call us at the Member Services number on your ID card.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



# Frequently asked questions

## What is LiveHealth Online<sup>®</sup>?

With LiveHealth Online, you have a doctor by your side 24/7. LiveHealth Online lets you talk face-to-face with a doctor through your mobile device or a computer with a webcam. No appointments, no driving and no waiting at an urgent care center.

Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections, allergies and more! It's faster, easier and more convenient than a visit to an urgent care center.

## Why would I use LiveHealth Online instead of going to visit my doctor in person?

LiveHealth Online is not meant to replace your primary care physician. However, it is a convenient option for care if your doctor is not available, or if you need care for common problems like a cold or the flu. LiveHealth Online connects you with a board-certified doctor in just a couple of minutes. Plus, you can get a LiveHealth Online visit summary from the *MyHealth* tab to print, email or fax to your primary doctor.

LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call **911** immediately.

## When is LiveHealth Online available?

Doctors are available on LiveHealth Online 24/7, 365 days a year.

## How do I access the LiveHealth Online mobile app?

You can download the LiveHealth Online mobile app for free on your mobile device by visiting the App Store or Google Play.

## Do doctors have access to my health information?

LiveHealth Online doctors can only access your health information and review previous treatment recommendations and information from prior LiveHealth Online visits.

If you are using LiveHealth Online for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit will be available for future LiveHealth Online visits.

## How does LiveHealth Online work?

When you need to see a doctor, simply go to **livehealthonline.com** or access the LiveHealth Online mobile app. Select the state you are located in and answer a few questions. Best of all, LiveHealth Online is a part of your health plan. So, the cost of a LiveHealth Online visit is the same or less than a primary care office visit.

Establishing an account allows you to securely store your personal and health information. Plus, you can easily connect with doctors in the future, share your health history and schedule online visits at times that fit your schedule.

Once connected, you can talk and interact with the doctor as if you were in a private exam room.

## How long does a LiveHealth Online session with a doctor usually last?

A typical LiveHealth Online session lasts about 10 minutes.

### How much does it cost to use LiveHealth Online?

LiveHealth Online is a part of your health plan. So, the cost of a LiveHealth Online visit is the same or less than a primary care office visit. To find out how much your visit will cost, enter your member ID on LiveHealth Online and the cost will be shown before you visit with a doctor.

Your family and friends also can use LiveHealth Online by paying the full cost of the visit, \$49.

### Will I be charged more if I use LiveHealth Online on weekends, holidays or at night?

No. The cost is the same.

### How do I pay for a LiveHealth Online session?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online visit with a doctor. Please keep in mind that charges for prescriptions aren't included in the cost of your doctor's visit.

### Can I get online care from a doctor if I'm traveling or in another state?

As long as you are located in a state where LiveHealth Online is available, you can get online care. To determine if online visits with a doctor are available in your state, please visit [livehealthonline.com](http://livehealthonline.com) and view the state map at the bottom of the home page.

### Why do some states offer prescriptions after my visit and other states don't?

Some state laws require a face-to-face visit before allowing prescriptions. Every state is different and these laws change often. Please visit [livehealthonline.com](http://livehealthonline.com) regularly to see if online visits with a doctor are available in your state. Please note that doctors using LiveHealth Online are not able to prescribe controlled substances or lifestyle drugs.

### Do I have what I need to access doctors through LiveHealth Online?

To find out how to use LiveHealth Online on your computer or mobile device, go to [livehealthonline.com](http://livehealthonline.com) and select the *About* tab. Then scroll down to the *More Information* section on the left side of the page.

### Who do I get in touch with if I still have questions?

You can email [customersupport@livehealthonline.com](mailto:customersupport@livehealthonline.com) or call toll free at 1-855-603-7985.

If you send us an email please be sure to include

- Your name
- Your email
- A phone number where you can be reached



And Its Affiliate HealthKeepers, Inc.

LiveHealth  
ONLINE

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.

Health and wellness programs are not covered services under the health plan, but are additions; these programs' features are not guaranteed under your health plan certificate and could be discontinued at any time. Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



# 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 requires understanding:

- Who can be enrolled.
- How coverage changes are handled.
- What's not covered by your plan.
- How your plan works with other coverage.

## Who can be enrolled

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- Your spouse
- Your children age 26 or younger, which includes:
  - A newborn, natural child or a child placed with you for adoption
  - A stepchild, or
  - 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 reached age 26.

## 1. On the employer level – which impacts you, as well as all employees under your employer's plan – your plan can be . . .

renewed	canceled	changed	when . . .
•			Your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	•		Your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or 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) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		•	Your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Lumenos coverage.

## 2. On an individual level – factors that apply to you and covered family members – your plan can be . . .

renewed	canceled	when . . .
•		You maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	•	You purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	•	You lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be canceled after you receive a written notice from us.



# The ins and outs of coverage

(continued)

## Special enrollment periods

Typically, you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is 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 may be instances other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage. But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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, if you 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, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

## When you're covered by multiple plans

If you're fortunate enough to be covered by more than one health plan, you may not be so thrilled about the paperwork hassles that can come with it when you're trying to figure out which plan should pay for what. Our Coordination of Benefits (COB) program helps ensure that you receive the benefits due and avoid overpayment by either carrier. Because up-to-date, accurate information is the key to our Coordination of Benefits program, you can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

If you are covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay a claim and provide reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.



# The ins and outs of coverage

(continued)

## Determining the primary versus secondary carrier

See the chart below for how determination gets made over which health plan is the primary carrier. The term “participant” is used and means the person who is signing 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 stipulated in 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	●	



# The ins and outs of coverage

(continued)

## How benefits apply when Medicare-eligible

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	Medicare is primary
Is a person who 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 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		●

## Recovery of overpayments

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. 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.



The following services and supplies will not be covered under your plan.

# The ins and outs of coverage

(continued)

## What's not covered (exclusions)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them. But, in order for us to keep the cost of health care as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered in any case.

### Applied behavioral therapy treatment

Your coverage does not include benefits for applied behavioral treatment (including but not limited to applied behavior analysis and intensive behavior interventions) unless otherwise covered by law.

### Biofeedback therapy

Over-the-counter **convenience** and hygienic items including, but not limited to, adhesive removers, cleansers, underpads, and ice bags

Certain prescription drugs if you could use a **clinically equivalent drug**, unless required by law. If you have questions about whether a certain drug is covered and which drugs fall into this group, visit our website at [anthem.com](http://anthem.com). If you or your doctor believes you need to use a different prescription drug, please have your doctor 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.

**Cosmetic surgery or procedures**, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance, including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause

functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

**Delivery charges** for the delivery of prescription drugs.

Your coverage does not include benefits for the following **dental or oral surgery services**:

- Shortening or lengthening of the mandible or maxillae for cosmetic purposes.
- Surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services.
- Dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia.
- Medications to treat periodontal disease.
- Treatment of natural teeth due to diseases.
- Treatment of natural teeth due to accidental injury unless you submitted a treatment plan to us for prior approval. No approval of a plan of treatment by us is required for emergency treatment of a dental injury.
- Biting and chewing related injuries unless the chewing or biting results from a medical or mental condition.
- Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth.
- Extraction of either erupted or impacted wisdom teeth.
- Anesthesia and hospitalization for dental procedures and services except as specified as otherwise being covered.
- Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures.
- Periodontal care, prosthodontal care or orthodontic care.



# The ins and outs of coverage

(continued)

**Donor** searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child, sibling)

**Educational**, vocational or self management training purposes, except as otherwise specified as being covered or when received as part of covered preventive care.

**Experimental/investigative** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. This will not prevent a member from being able to appeal Anthem's decision that a service is not experimental/investigative.

## Family planning

- Artificial insemination services, in vitro fertilization or any other types of artificial or surgical means of conception, including drugs administered in connection with these procedures
- Drugs used to treat infertility
- Any services or supplies provided to a person not covered that is in connection with a surrogate pregnancy, including, but not limited to, the bearing of a child by another woman for an infertile couple
- Services to reverse voluntarily induced sterility

## Services for palliative or cosmetic foot care

- Flat foot conditions
- Support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- Foot orthotics
- Subluxations of the foot
- Corns, calluses and care of toenails (except in treatment for patients with diabetes or vascular disease)
- Bunions (except capsular or bone surgery)

- Fallen arches, weak feet, chronic foot strain
- Symptomatic complaints of the feet

**Gene therapy** as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Services for surgical treatments of **gynecomastia** for cosmetic purposes

**Health club memberships**, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

**Hearing aids** or for examinations to prescribe or fit hearing aids, except for cochlear implants, are not covered.

## Home care services

- Homemaker services (except as rendered as part of Hospice care)
- Maintenance therapy
- Food and home-delivered meals
- Custodial care and services

## Hospital services

- Guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay
- Care by interns, residents, house physicians, or other facility employees that are billed separately from the facility
- A private room, unless it is medically necessary

**Immunizations** required for travel or work, unless such services are received as part of the covered preventive care services

Refills of **lost or stolen drugs**.



# The ins and outs of coverage

(continued)

## Medical equipment (durable), appliances, devices and supplies as outlined below:

- items that have both a non-therapeutic and therapeutic use, including but not limited to exercise equipment; air conditioners, humidifiers, and purifiers; hypoallergenic bed linens, bed boards; whirlpool baths; handrails, ramps, elevators and stair glides; telephones; adjustments made to a vehicle; foot orthotics; and changes made to a home or place of business;
- replacement or repair of purchased or rental equipment because of misuse, abuse or loss/theft;
- surgical supports, corsets or articles of clothing unless needed to recover from surgery or injury;
- non-medically necessary enhancements to standard equipment and devices; and
- supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary. Reimbursement will be based on the maximum allowed amount for the standard item which is a covered service, serves the same purpose, and is medically necessary. Any expense that exceeds the maximum allowed amount for the standard item will be the member's responsibility.

## Medical equipment (durable) that is not appropriate for use in the home.

Services or supplies deemed not **medically necessary** as determined by us at our sole discretion. Notwithstanding this exclusion, all preventive care services and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by us to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and

management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal our decision that a service is not medically necessary.



## Experimental ... or not?

Many of our medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

- Regulatory approval from the Food and Drug Administration.
- Been put through extensive research study to find all the benefits and possible harms of the technology.
- Benefits that are far better than any potential risks.
- At least the same or better effectiveness as any similar service or procedure already available.
- Been tested enough so that we can be certain it will result in positive results when used in real cases.



# The ins and outs of coverage

(continued)

## Mental health and substance use

- Inpatient stays for environmental changes
- Cognitive rehabilitation therapy
- Educational therapy
- Vocational and recreational activities
- Coma stimulation therapy
- Services for sexual deviation and dysfunction
- Treatment of social maladjustment without signs of a psychiatric disorder
- Remedial or special education services

**Nutrition** counseling and related services, except when provided as part of diabetes education, mental health treatment of an eating disorder or when received as part of a covered preventive care services visit or screening.

**Nutritional** and/or dietary supplements, except as specifically listed in this enrollment brochure or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

**Obesity** services and supplies 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. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

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

**Organ** or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the

procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high-dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

## Paternity testing

### Prescription drug benefits

- Administrative charges: Charges for the administration of any drug except for covered immunizations as approved by us or the Pharmacy Benefits Manager.
- Clinically-equivalent alternatives - certain prescription drugs may not be covered if a member could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members will give 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, visit our website at [anthem.com](http://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.

- Compound drugs: Compound drugs unless all of the ingredients are FDA-approved and 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.



# The ins and outs of coverage

(continued)

- Contrary to approved medical and professional standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery charges: Charges for delivery of prescription drugs.
- Drugs given at the provider's office/facility: Drugs you take at the time and place where you are given them or where the prescription order is issued. This includes samples given by the doctor. This exclusion does not apply to drugs used with diagnostic services, drugs used during chemotherapy in the office, or drugs covered under the medical supplied benefit; those would be covered services.
- Drugs not on the Anthem prescription drug list (a formulary): You can get a copy of this list by calling us or visiting us at [anthem.com](http://anthem.com). If you or your doctor believes you need a certain prescription drug not on the list, please refer to the "prescription drug benefits at a retail or home delivery (mail order) pharmacy" section in your post enrollment *Evidence of Coverage* for details on requesting an exception.
- 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.
- Drugs over the quantity or age limits: Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
- Drugs over the quantity prescribed or refills after one year: Drugs in amounts over the quantity prescribed, or for a refill given more than one year after the date of the original prescription order.
- Drugs prescribed by providers lacking qualifications/certifications. Prescription drugs prescribed by a provider who does not have the necessary qualifications, including certifications, as determined by us.
- Gene therapy as well as any drugs, procedures, health care services related to it that introduce or relate to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- Infertility treatments: Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- Items covered as durable medical equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers and blood glucose monitors. Items not covered under the prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit may be covered under the medical equipment (durable) or medical supplies benefit.
- Items covered the medical supplies and medications benefit: Allergy desensitization products or allergy serum. While not covered under the "prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy" benefit, these items may be covered under the medical supplies and medications benefit.
- Mail-order providers other than our home delivery mail-order provider: Prescription drugs dispensed by any mail order provider other than our mail order provider unless we must cover them by law.
- Non-approved drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless we must cover the use by law or if we, or the Pharmacy Benefits Manager, approve it.
- Onychomycosis drugs: Drugs for Onychomycosis (tonail fungus), except when we allow it to treat members who are immuno-compromised or diabetic.
- Over-the-counter items: Drugs, devices and products, or prescription legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device or product. This includes prescription legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over the counter products that we must cover under federal law with a prescription.
- Sexual dysfunction drugs: Drugs to treat sexual or erectile problems.



# The ins and outs of coverage

(continued)

- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight loss drugs: Any drug mainly used for weight loss. 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.

Your coverage does not include benefits for **private duty nurses** in an inpatient setting.

**Residential accommodations** to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility, or residential treatment center.

**Rest cures**, custodial, residential or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic service.

**Services or supplies or devices:**

- Not listed as covered under your health plan
- Not prescribed, performed, or directed by a provider licensed to do so.
- Received before the effective date or after a covered person's coverage ends.
- Services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- Benefits for charges from stand-by physicians in the absence of covered services being rendered.
- Telephone consultations, charges for not keeping appointments, or charges for completing claim forms.

**Services or supplies** if provided or available to a member:

- Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government

program the secondary payor after benefits under this plan have been paid.

- Provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government.

**Services** for which a charge is not usually made including those services for which you would not have been charged if you did not have health care coverage services or benefits for:

- Amounts above the allowable charge for a service
- Neurofeedback, and related diagnostic tests
- Penile implants

**Services or supplies** if they are received from providers not licensed by law to provide services. Examples include masseurs (massage therapists), physical therapist technicians and athletic trainers.

Benefits for services or supplies to treat **sexual dysfunction** (male and female sexual problems). This includes medical and mental health services.

**Skilled nursing facility stays**

- Treatment of psychiatric conditions and senile deterioration
- Facility services during a temporary leave of absence from the facility
- A private room unless it is medically necessary

**Smoking cessation** programs not affiliated with us

**Spinal manipulation** and manual medical interventions for an illness or injury other than musculoskeletal conditions.

**Telemedicine**

Non-interactive telemedicine services, including audio-only telephone, electronic mail message, facsimile transmissions or online questionnaire.



# The ins and outs of coverage

(continued)

## Therapies

- Physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- Group speech therapy
- Group or individual exercise classes or personal training sessions
- Recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

Services for treatment of varicose veins or telangiectatic dermal **veins** (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes

## Vision services

- For members through age 18, there is no benefit for frames or contact lenses purchased outside of our formulary.
- Vision services or supplies, unless needed due to eye surgery and accidental injury
- Routine vision care and materials
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure
- Services for vision training and orthoptics
- Tests associated with the fitting of contact lenses, unless the contact lenses are needed due to eye surgery or to treat accidental injury
- Sunglasses or safety glasses and accompanying frames of any type

- Any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- Any lost or broken lenses or frames
- Cosmetic lens options that are not otherwise specifically listed as covered.
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- Any other vision services not specifically listed as covered

## Waived cost shares

Your coverage does not include waived cost shares out-of-plan. For any service in which you are responsible under the terms of this plan to pay a copayment, coinsurance or deductible, and the copayment coinsurance or deductible is waived by an out-of-network provider.

**Weight loss programs** whether or not they are pursued under medical or physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers®, Jenny Craig®, LA Weight Loss®) and fasting programs.

Services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.



# Let's talk about your privacy and rights

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And you also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to [www.anthem.com/memberrights](http://www.anthem.com/memberrights). To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

## How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, visit [www.anthem.com/memberrights](http://www.anthem.com/memberrights). To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

## Special Enrollment Rights

There are certain situations when you can enroll in a plan outside the open enrollment period. Open enrollment usually happens only once a year. That's the time you can enroll in a plan or make changes to it. If you choose not to enroll during open enrollment, there are special cases when you're allowed to enroll yourself and your dependents. Special enrollment is allowed:

- **If you had another health plan that was canceled.** If you, your dependents or your spouse are no longer eligible for

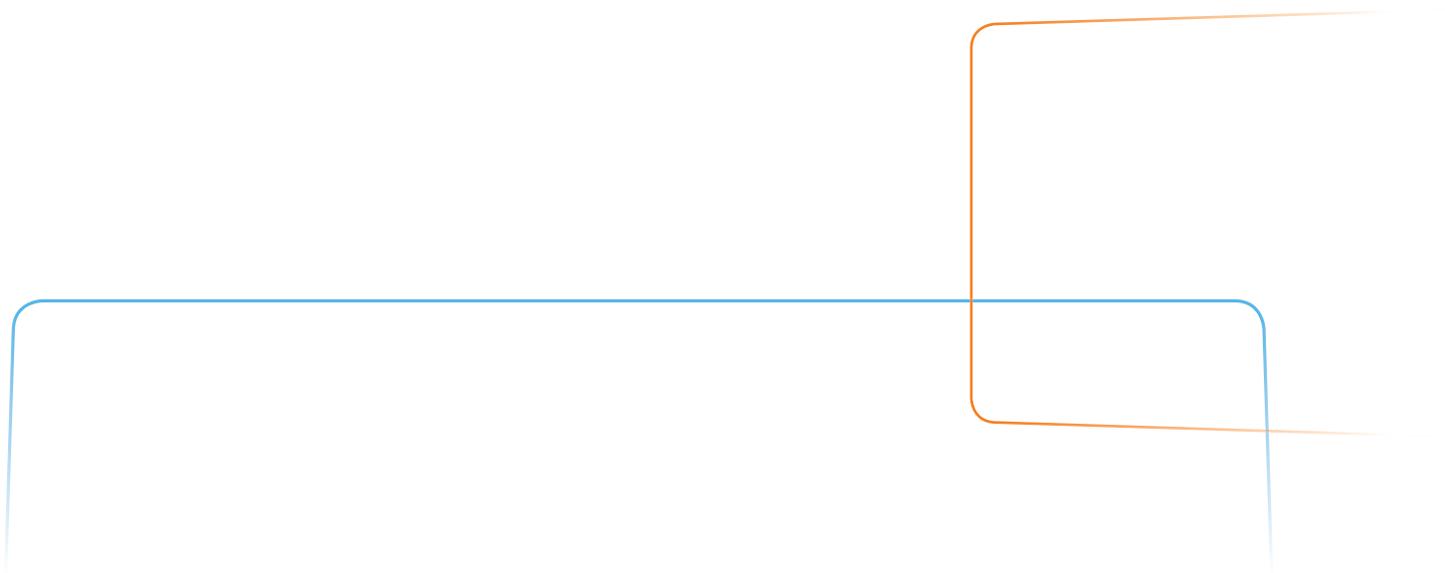
other coverage (or if the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it).

- For example: You and your family are enrolled through your spouse's coverage 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 a plan.
- **If you have a new dependent.** This could mean a life event like 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 got married, 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 CHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.









# You've got health goals We've got your back.

## If you need more information

KeyCare PPO Member Services 1-800-451-1527

Lumenos HDHP-HSA Member Services 1-800-582-6941



And Its Affiliate HealthKeepers, Inc.

These policies have 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, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: Group Policy GP-1 (7/02), GP-TOC, GP-ELIG (1/14) and GP-GEN (1/17), PP-INTRO (1/17), P-TOC (1/15), P-SB6 (1/17), P-SB7 (1/17), P-WORKS (1/17), P-COVERED (1/17), P-EXCL (1/17), P-CLAIMS (1/17), P-COB (1/16), P-ENR (1/15), P-ENDS (1/17), P-INFO (1/17), P-RIGHTS (1/17), P-DEF (1/17), P-EXH-A (1/17), P-INDEX (1/14). Enrollment application used for these plans: 490773 (7/15). This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area. Life and Disability products underwritten by Anthem Life Insurance Company. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.