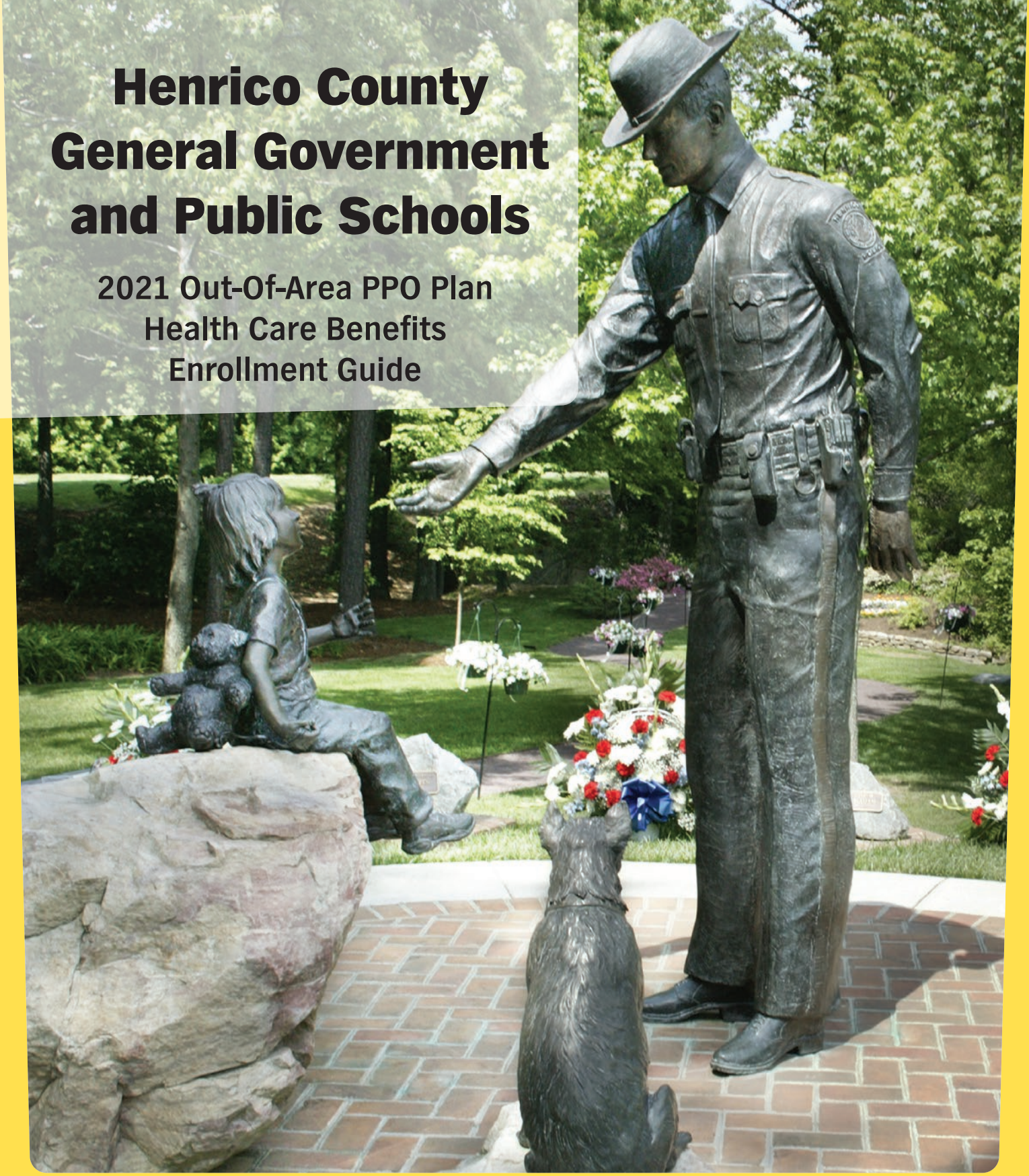
Henrico County General Government and Public Schools

2021 Out-Of-Area PPO Plan Health Care Benefits Enrollment Guide



County of Henrico
General Government

HCPS
Henrico County Public Schools

Anthem

Administered by Anthem Blue Cross and Blue Shield

Henrico County General Government and Public Schools
KeyCare PPO Plan
important contact information

Important phone numbers to keep handy

Member Services

1-833-630-6742 Eastern Standard Time

Monday through Friday 8:00 am to 6:00 pm

24/7 NurseLine

1-800-337-4770

BlueCard Access

1-800-810-2583

Mail Order Pharmacy Services

1-866-281-4279

Provider Services (in case your doctor needs to contact Anthem to coordinate a service for you or obtain an authorization)

1-833-630-6742

Pre-Authorization (for members who choose to go out-of-network)

1-833-630-6742

Mental Health Services (for services requiring pre-authorization)

1-800-991-6045

Blue View Vision

Call Member Services at 1-833-630-6742

Visit us at anthem.com

Fast facts

Anthem Blue Cross and Blue Shield has been serving the health care needs of Virginians for more than 75 years. We have offices throughout the state, including Richmond, Virginia Beach, Roanoke, Lynchburg and Northern Virginia.

Anthem, Inc. is an independent licensee of the Blue Cross and Blue Shield Association serving members in 14 states. With 7,000 employees in VA and more than 52,000 employees nationwide, we are able to leverage national networks and resources while still providing strong local presence and support. That's good news for the 38 million members we serve - roughly one in every nine Americans.

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Welcome to Anthem KeyCare benefits

We're glad you're taking time to check out all that Anthem KeyCare has to offer you. We are excited for the opportunity to provide health plan coverage to Henrico County General Government and Public Schools for the upcoming year. Choosing your benefits is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with Anthem KeyCare coverage. It shows what's available to you, what you get with each benefit and how the plans work.

Explore the Anthem KeyCare membership advantage.

We know you're busy. That's why we've made sure it only takes a few moments to explore the advantages of being an Anthem KeyCare member, including:

- **There's a good chance your doctor is part of Anthem KeyCare's network. To find out, go to anthem.com and search the Find a Doctor tool.**
- **You get more than access to coverage. You also get tools, resources and guidance that may help you reach your personal, healthy best.**
- **Our web site - anthem.com - has the answers you need. Simply go to anthem.com for answers to your claims questions and find detailed health benefit information.**
- This booklet goes into all this — and more. Please take a few minutes to look over the information, and keep this booklet. It may come in handy.

Registering on anthem.com is step one.

Once you get your ID card, registering is easy; all you need is your ID card, the Internet and five minutes. After you register at anthem.com, you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

- Go to anthem.com
- Click on the Register now link and follow the instructions to create your user name and password and you're ready to go!

Read on for information to help you choose your benefits with confidence. If you have any questions, your benefits manager will be happy to answer them. Thanks for considering Anthem KeyCare.

The out-of-area PPO plan is available for employees and early retirees whose primary residence is outside of the Anthem HealthKeepers service area.

Your health benefits

Your member ID card

Your Member ID card is the first step in using your health care benefits. Once Anthem receives your information from Henrico County General Government and Public Schools, you will receive an ID card. Members will usually receive their ID cards within 10 working days after Anthem has processed the enrollment/change.

The ID card lists the subscriber's member number, the group number and the date the benefits described on the card begin for that member. Each covered family member will receive a separate ID card.

The member number is a system-generated number. Please review the ID card to make sure the information is correct. If any information is incorrect, contact Henrico County General Government and Public Schools.

If you need additional cards, you can print them at your convenience by logging in to anthem.com. You may also contact Member Services at 1-833-630-6742 to request a card. It is important that you present your ID card prior to receiving medical care.

Take care of yourself

Remember to get preventive care

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

Our health plans and policies cover 100% of the services in this preventive care listing.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket.

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.

Sometimes routine screenings reveal abnormalities or problems that require immediate intervention or additional diagnosis. When this happens, the additional necessary procedures are considered diagnostic and/or surgical, and may be covered at a different level under your medical benefit. This could affect your member cost share.

For example, say your doctor suggests you have a colonoscopy because of your age. That's preventive care. On the other hand, say your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care and you may need to pay part of the cost.

Here's an overview of the types of preventive services we cover. See your benefits summary to learn more.

Child preventive care (birth through 18 years, unless otherwise noted)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening test (depending on your age) may include

- Behavioral screening and 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)
- Iron supplements for children 0-12 months[6]
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Vision screening[2] when done as part of a preventive care visit

Immunizations (if provided by a medical provider)

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

Take care of yourself

Remember to get preventive care

Adult preventive care (19 years and older, unless otherwise noted)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests and services (depending on your age) may include

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- Breastfeeding support, supplies and counseling (female)[3,4]
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Contraceptive (birth control) counseling, FDA-approved contraceptive medical services provided by a doctor, including sterilization (female)[4]
- Depression screening
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- Hepatitis C virius (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- HIV screening and counseling
- HPV screening (female)[4]
- Intervention services (includes counseling and education):
  - Behavioral counseling to promote a healthy diet
  - Counseling related to aspirin use for the prevention of cardiovascular disease
  - Counseling related to genetic testing for women with a family history of ovarian or breast cancer, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met
  - Counseling related to chemoprevention for women with a high risk of breast cancer
  - Primary care intervention to promote breastfeeding[3,4]
  - Screening and behavioral counseling related to alcohol misuse
  - Screening and behavioral counseling related to tobacco use
  - Screening and counseling for interpersonal and domestic violence
  - Screening and counseling for obesity
- 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
- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)[4]
- Screening and counseling for sexually transmitted infections

Immunizations (if provided by a medical provider)

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A
- Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- MMR
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

This sheet is not a contract or policy with Anthem. If there is any difference between this sheet and the Plan Document for County of Henrico Health Plan (Plan Document), the Plan Document will govern. Please see the Plan Document for Exclusions and Limitations.

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 Care number on your ID card.

2 Additional vision services are available through Blue View Vision. Refer to the Blue View Vision section on page 45 for more information.

3 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.

4 This benefit also applies to those younger than 19.

Find a doctor online

We believe that finding a doctor online is one of the top reasons many of you visit our website. That's why we keep working on our Find a Doctor tool to make it better. Here's how you can get information about doctors in your area.

For members

1. Visit anthem.com and log in.
2. Select the **Find a Doctor** tool on the right side of the page.
3. Select the type of doctor you're looking for.
4. Select **Search**.

For non-members

1. Go to anthem.com to find a listing of available providers.
2. Select **Menu** and then choose **Find a doctor**.
3. Answer a few questions, so we can help find you the right plan and doctor in your plan.
4. Enter or select the plan/network.*
5. Select a type of provider, place or name.
6. Select **Search**.

*For your plan, pick "Anthem KeyCare (PPO)".

To search for doctors, hospitals, pharmacies and more from your mobile device, go to anthem.com. Or, download our free app from the App Store on your Apple or Android mobile device. Search Anthem Blue Cross and Blue Shield and download.

Sydney, Anthem's mobile app — your benefits at your fingertips
Using our mobile app can make it easier to manage your health care.
You can do things like:

1. Find a doctor.
2. Get your ID card.
3. Check your claims.
4. Estimate your costs.

To download the app:

1. Go to the App Store® or Google Play™ on your mobile device.
2. Search for "Sydney Anthem."
3. Select the app and download for free.

If you are searching for a provider out of state, scroll down the Medical Plan Employer-sponsored options until you see National PPO / BlueCard PPO to insure the largest list of providers are given to you.

Emergency and urgent care

Our plans provide coverage for medical emergencies, no matter where they occur. But it is important for you to understand the difference between an emergency and an urgent situation.

If you are experiencing a medical emergency, get the care you need. It would be best to go to the nearest participating hospital emergency room (ER). Hospital ERs that do not participate with us should only be used if the delay in receiving care from a participating ER could reasonably be expected to cause your condition to get worse.

If you are admitted to a non-participating hospital in an emergency, you must let us know within 48 hours or by the next working day if the 48-hour deadline falls on a weekend or legal holiday. An exception to this requirement is made if you are incapacitated and unable to contact us. In this case, you must make arrangements to notify us as soon as possible.

What is a medical emergency?

A medical emergency is the sudden onset of a medical condition, such as unusually severe symptoms. You should seek immediate medical attention if the condition could result in serious jeopardy to your mental or physical health, serious impairment of your bodily functions, serious dysfunction of any of your bodily organs, or if pregnant, serious jeopardy to the health of the baby.

When to call your PCP before seeking care

If an emergency occurs and time permits or if you are not sure you are experiencing a medical emergency, call your PCP, even if you are on vacation. Your PCP's office may have a doctor "on call" 24 hours a day, seven days a week.

Where to go for care

If you have an unexpected illness or injury while in the service area that requires immediate treatment, call your PCP. Your PCP may be able to see you in the office or suggest temporary measures to take before an office visit. If this is not possible, your PCP may advise you to visit one of our participating urgent care centers. You can also call the 24/7 toll-free NurseLine to speak with a registered nurse who will advise you on where to go.

Convenient care for members

Members can use a Patient First physician as their PCP. You will pay the PCP copayment when you receive care from a Patient First physician. This gives you greater flexibility to access primary care services in the Richmond area.

When out of the service area

If you have an unexpected illness not usually associated with urgent care while you are out of the service area, we may pay for treatment at an urgent care facility. For urgent care outside the service area, call the number on your member ID card.

Emergency and urgent care

Medical Emergency Examples

Some examples of a medical emergency include, but are not limited to:

Severe or unusual bleeding
Trouble breathing
Chest pain
Choking
Suspected poisoning
Convulsions or seizures
Broken bone
Fainting or unconsciousness
Any vaginal bleeding in pregnancy

What is not a medical emergency?

As a single symptom, these are not emergencies. Call your PCP for these problems:

Coughing
Diarrhea
Sore throat
Colds
Stomach ache
Rashes
Vomiting
Earache
Toothache
Pink eye
Mild fever
Bruises

Note: your claim may be denied if you go to the emergency room when it is not a true emergency.

Urgent care examples

When a minor illness or injury occurs unexpectedly and your doctor's office is closed, consider using an urgent care center. Some examples of urgent care are:

Sprains
Non-severe bleeding
Simple cuts that require stitches

24/7 Nurseline

Round the clock access to health information can help give you peace of mind and your physical well being. That's why we have nurse coaches ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 toll-free Nurseline to get answers to questions like these:

Can the problem be treated at home?

Do you need to see your doctor?

Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach the 24/7 Nurseline, call 1-800-337-4770.

Coverage while traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting the Anthem network with those of other Blue Cross and Blue Shield companies across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com or call the Member Services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. Call Anthem Member Services to verify your coverage.
3. Show your ID card at the time of service.
4. As an Anthem KeyCare member, you are covered for office visits and other services at the same cost as out-of-network visits when you are at home.

You pay the same with any Blue Cross and Blue Shield provider as you would an Anthem network provider. Plus the provider will file your claims for you. Anthem will still mail your explanation of benefits so you can double-check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 48 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.

Make the most of your benefits with these smart tips

Action Step #1: Ask about other facilities that can perform certain procedures

Since hospitals have higher overhead costs, their rates are usually higher for inpatient and outpatient services. If you can have your service or procedure done at a doctor's office, surgery center, or free-standing radiology center instead, you might have lower out-of-pocket costs. For many services at these places, you'll probably only pay a copayment (a set amount) instead of a coinsurance (a percentage).

Action Step #2: Ask about your options for radiology services

The cost for radiology services can vary depending on where they're done. For example, in one office you may only be charged a copayment, while another facility may require a coinsurance. So, if it's not an emergency, be sure to check with your doctor about your radiology options.

Action Step #3: Comparison shop with the Estimate Your Cost tool

Know how much a procedure will cost before having it done. With the Estimate Your Cost tool, you get side-by-side cost estimates at area facilities for more than 400 procedures, such as knee replacement, maternity services and tonsillectomy. Check out our demo at anthem.com.

Action Step #4: Avoid using emergency rooms for conditions that aren't life-threatening

Services cost a lot more in the ER than they would in your primary care or family doctor's office. For minor stuff like minor cuts and sprains, ear infections, urinary tract infections and bronchitis, you would save money by avoiding the ER altogether. If it's not life-threatening, consider making an appointment instead. You may also save time; waiting in the ER takes longer than waiting in your doctor's lobby.

Talk to a doctor today, tonight, anytime — 365 days a year. LiveHealth Online uses two-way video chat to connect you with doctors over the Internet. You don't need to schedule an appointment, drive to the doctor's office and wait for your appointment. You don't even have to leave your home or office. Doctors can answer your questions, make a diagnosis and even prescribe basic medications. Go to LiveHealthOnline.com and set up your personal account.

Action Step #5: Take advantage of those preventive benefits

Immunizations, mammograms and annual checkups help you stay healthy. That's why preventive services like these are covered by your plan. Don't forget to use them. They can help prevent costly chronic conditions such as diabetes and high blood pressure, which mean more services, more doctor visits, and more money out of your pocket. Your entire collection of wellness benefits can be found at anthem.com, or by calling the Member Services number on your ID card.

Small things add up.

Some people just know how to get the absolute most from their benefits. They're experts at finding extra dollars in the corners and corridors of the health care system. They're also skilled at using plan features to their advantage. You too can be one of these in-the-know experts. Here are their secrets.

Make the most of your benefits with these smart tips

Action Step #6: Keep an eye on your EOB

You'll get an Explanation of Benefits (EOB) whenever you use your benefits and you owe a cost share. It's like your personal claim and coverage report. When you get one, make sure it's accurate and that it includes only the services you received. If you're ever not sure about a charge, call Member Services and we can help clear things up.

Action Step #7: Surround yourself with support from Anthem's Health and Wellness Programs

Anthem has many Health and Wellness Programs that support you with the help you need to live healthier, feel better and save money. Personalized information, 24/7 access to a nurse, and trained health management professionals — it's all ready to help you navigate the health care system and use your benefits wisely. And it's part of your plan at no extra cost. Start by taking a MyHealth Assessment at anthem.com, which can analyze the choices you make and provide suggestions for the steps you can take.

Action Step #8: Use in-network doctors and hospitals

They'll cost less than out-of-network doctors. Anthem contracts with doctors and hospitals to offer services for our members at a discounted rate. These "in-network" doctors agree to accept this discounted rate as payment in full and can't balance-bill you. Doctors who aren't contracted with Anthem are considered "out-of-network." If you visit an out-of-network doctor, your out-of- pocket costs may be higher because the discount won't apply and they can balance-bill you for the difference. Don't assume that all doctors and hospitals are in our network. Before seeking services, check our Find a Doctor tool at anthem.com; if they're not on Find a Doctor, most likely they're out-of-network. You can also call your doctor or the Member Services number on your ID card.

Action Step #9: Get health tips from anthem.com

At anthem.com, you'll find plenty of expert information to help you stay on top of your health care options, costs and ways to improve your health. Take a few moments, explore the website and learn more. You can also call Member Services for more help.

Register today at anthem.com

From your computer:

- Go to anthem.com and select Register Now
- Provide the personal information requested
- Create a username and password
- Set your email preferences
- Select Submit

From your mobile device:

- Download the free Anthem mobile app and select Register Now
- Confirm your identity
- Create a username and password
- Set your email preferences
- Confirm and select Register

Anthem KeyCare PPO Plan

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

With no primary doctor requirement and no referrals, you're free to make your own decisions about your health care.

Anthem KeyCare is a PPO plan, which means you're free to choose your doctor without referrals. Of course, in-network care will usually cost less than out-of-network care. The network includes most doctors and hospitals across the nation, so you'll find plenty of choices. The point is, the choice is yours.

As an Anthem member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health and your budget.

Anthem KeyCare PPO at a glance

- *Primary care physicians (PCPs):* Not required
  You can make your own decisions about your doctors, your care and your costs.
- *Referrals:* Not needed.
- *Claim forms:* No claim forms to submit when using network providers.
- *Out-of-network benefits:* Available, but at lower coverage levels than in-network.
  We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- *Out-of-pocket:* This is the amount you'll pay for the cost of covered services.

You can see what services cost before your visit

Through anthem.com, you can estimate the costs for inpatient and outpatient services and doctor visits. What better way to help you determine what to do?

Anthem KeyCare PPO Plan (continued)

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency, urgent or approved follow-up care, you have three options. Go to anthem.com, call BlueCard® PPO Access at 800-810-2583 or call the Member Services number on your member ID card.

You're getting more than a health plan

You get programs to actually help you manage your health. Wellness tools, Health and Wellness management programs, and Family and Home Special Offers are all available through anthem.com. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your benefits summary contains the details.

Your Benefits

Anthem

Henrico County General Government and Public Schools
Anthem KeyCare PPO Plan

Covered Services (not subject to deductible)	IN-NETWORK You Pay
Preventive Care Services	
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 your 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 your provider, which may result in a member cost share.	***No Charge**
Outpatient Services	
o mammograms	**No Charge**
o maternity services for all routine outpatient pre-and postnatal care (excluding inpatient stays)	**$50** copay
Routine Vision	
o annual routine eye exam *Administered by Blue View Vision*	**$15** for each visit
All Other Services (subject to deductible)	
You will pay all the costs associated with your care until you have paid $400 per Individual/$800 per Family in one plan year. This is known as your deductible. Once you reach your deductible you pay:	
Doctor Visits	
o office visits o urgent care visits o wisdom teeth extractions (bony impacted only) o in-office surgery o voluntary family planning o allergy testing	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
o allergy serum and allergy injections (if actual cost of serum and injection is less than the Allowable Charge, member is only charged actual cost)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Labs, Diagnostic X-rays	
o diagnostic tests o diagnostic x-rays o lab work	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
o advanced diagnostic imaging services (includes MRI, MRA, MRS, CTA, PET scans and CT scans)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Emergency Care	
o true emergency care visits in or out of the service area	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
o early intervention services	Member cost shares will be dependent on the services rendered after deductible.

Autism Spectrum Disorder (ASD)	

• diagnosis and treatment of autism spectrum disorder including:
  • behavioral health treatment*
  • psychiatric care
  • therapeutic care**
  • psychological care
**** Mental Health Services***
*****Unlimited physical, occupational and speech therapy.***
	Member cost shares will be dependent on the services rendered after deductible.

• applied behavioral analysis	**20%** of the amount the health care professionals in our network have agreed to accept for their services (after deductible, except for services related to preventive care)
Other Outpatient Services	
• ambulance travel	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• physical, occupational and speech therapy • spinal manipulation and manual medical therapy services ***(Limited to 30 visits per plan year)***	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• infusion therapy • chemotherapy • radiation therapy • dialysis • cardiac rehab therapy	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• surgery in a hospital or facility (including bony impacted wisdom teeth extractions)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• hospice care • home health care ***(Limited to 90 visits per plan year)***	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
• durable medical equipment • medical supplies	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• prosthetic devices	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services
• mental health and substance abuse visits	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services

Inpatient Stays in a Hospital or Facility	
o semi-private room o private room when approved in advance o intensive or coronary care unit o maternity services o mental health and substance abuse services o occupational, speech and physical therapy o skilled nursing facility (100 days for each admission)	**20%** after deductible of the amount the health care professionals in our network have agreed to accept for their services

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 $1,000 in one calendar or plan year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $1,000 of the cost of your care ($2,000 total).
- If three or more people are covered under your plan, together you will pay the first $2,000 of the cost of your care. However, the most one family member will pay is $1,000.

Once you have reached this amount, when you receive covered services you will pay 30% and we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. What you pay includes 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 (this is referred to as balance billing). 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 $1,000 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 in-plan professionals
If you are the only one covered by your plan, you will pay $2,500 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 $2,500 ($5,000 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 $2,500 toward the limit.

When not using out-of-plan professionals
If you are the only one covered by your plan, you will pay $2,500 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 $2,500 ($5,000 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 $2,500 toward the limit.

When using in-plan professionals and out-of-plan professionals
The amounts referenced above for in-plan and out-of-plan professionals do not cross accumulate. Therefore, you are responsible for the separate amounts for in-plan and out-of-plan based on the providers you are using.

The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:
- the costs associated with vision benefits
- the cost of care received when the benefit limits have been reached
- the cost associated with prescription drugs

Under the Affordable Care Act, medical and behavioral costs all count toward one combined out of pocket maximum.
Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.

This benefits overview insert is only one piece of your entire enrollment package.

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.

Tips for understanding your coverage

Knowing the “rules of the road” for the plan you have selected can make all the difference in getting the most value from your Anthem coverage. Here are a few tips to keep in mind when seeking services.

Services that require advance reviews

While you can see any doctor or go to any hospital you like in-network, there may be instances in which a test or procedure your doctor wants you to have may not be covered. To help you minimize unanticipated costs from a non-covered service, we work with our in-network providers to make sure that certain services go through an advance review process first. This way, you’ll know upfront whether the service is going to be covered.

Balance billing

In some situations, such as an emergency, getting the care you need is the first priority. During these times, if you receive care from hospitals and/or providers who have not contracted with us, they can charge whatever they want for their services. If what they charge is more than providers in our network have agreed to accept for the same service, you can be billed for the difference. This is called “balance billing.”

The best way to avoid balance billing is to:

- use in-network doctors, hospital and other providers, including labs and x-ray facilities;
- know what services are covered by your health plan; and
- make sure to get prior authorization for a medical service, if required.

Ins and outs of coverage

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 until reaching age 26, including a newborn, biological child, adopted child, child placed with you for adoption; see the Plan Document details.

Coverage will end on the last day of the month in which children 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.

The ins and outs of coverage (continued)

Your Anthem KeyCare plan can be ...

renewed	cancelled	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 cancelled after you receive a written notice from us.

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 towards your or your dependents' other coverage. But, you must ask to be enrolled within 60 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 60 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 Benefits Office.

Members will need to notify their Benefits Office if a dependent loses eligibility for coverage, such as a former spouse at divorce, or a child over age 26.

The ins and outs of coverage (continued)

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, if applicable, for any remaining available benefits.

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	Anthem KeyCare	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		●

The ins and outs of coverage (continued)

When a person is covered by Medicare and a group plan, and	Then	Anthem KeyCare	Medicare is Primary
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; and
- any other organization.

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 from. 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.

acupuncture unless otherwise specified

biofeedback therapy

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

The ins and outs of coverage (continued)

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.

dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem. Other dental services that will not be covered by your plan including the following as listed below:

- 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
- 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
- anesthesia and hospitalization for dental procedures and services except as specified in the plan document

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

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.

The ins and outs of coverage (continued)

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
- non-prescription contraceptive devices
- 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

Experimental ... or not?

Many of the Anthem 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; and
- been tested enough so that we can be certain it will result in positive results when used in real cases.

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.

These services are not covered by your Anthem KeyCare plan.

The ins and outs of coverage (continued)

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 care except in relation to preventive care screenings (Implantable or removable 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 to if 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

medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use:

- exercise equipment
- air conditioners, dehumidifiers, humidifiers, and purifiers
- hypoallergenic bed linens
- whirlpool baths
- handrails, ramps, elevators, and stair glides
- telephones
- adjustments made to a vehicle
- foot orthotics
- changes made to a home or place of business
- repair or replacement of equipment you lose or damage through neglect

medical equipment (durable) that is not appropriate for use in the home

These services are not covered by your Anthem KeyCare plan.

The ins and outs of coverage (continued)

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
  - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital
  - group psychotherapy when there are more than 8 patients with a single therapist
  - group psychotherapy when there are more than 12 patients with two therapists
  - more than 12 convulsive therapy treatments during a single admission
  - psychotherapy provided on the same day of convulsive therapy

non-medically necessary services and supplies as determined by Anthem at its sole discretion. Notwithstanding this exclusion, all preventive care 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 Anthem 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 Anthem's decision that a service is not medically necessary.

The ins and outs of coverage (continued)

nutritional counseling and related services, as specifically provided by the health plan or except when provided as part of diabetes education, for treatment of an eating disorder, or when received as part of a covered preventive care visit

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.

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 received from a retail or home delivery (mail order) pharmacy. This exclusion does not apply to prescription medications for palliative care and pain management provided as part of hospice care services and prescription drugs provided through clinical trials for cancer.

private duty nurses in the inpatient setting

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

- received from providers not licensed by law to provide covered services defined in this Booklet. Examples include masseurs (massage therapists), physical therapist technicians, and athletic trainers
- 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

These services are not covered by your Anthem KeyCare plan.

The ins and outs of coverage (continued)

- for injuries or illnesses incurred as a result of your commission of, or attempt to commit, a crime
- 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
- self-administered services or self care including self-administered injections
- self-help training
- neurofeedback, and related diagnostic tests

services or supplies primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered preventive care visit or screening

sexual dysfunction (male and female sexual problems) services or supplies, including 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

These services are not covered by your Anthem KeyCare plan.

The ins and outs of coverage (continued)

smoking cessation programs not affiliated with us

spinal manipulation and manual medical therapy services for an illness or injury other than musculoskeletal conditions

telemedicine

- non-interactive telemedicine services such as, audio only telephone conversations, electronic mail message, facsimile transmissions or online questionnaire.

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

- 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 specifically listed in the Summary of benefits

These services are not covered by your Anthem KeyCare plan.

The ins and outs of coverage (continued)

- 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

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, etc.) 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.

Additional benefits

Blue View Vision℠

Vision care is not just for eyeglass wearers. Routine eye visits are important for everyone in preventing eyesight damage. In fact, eye exams can also help detect other health problems. Blue View Vision exists so you can get the vision care you need without feeling like you're busting your budget.

Advantages of Anthem Blue View Vision:

- **You have access to eye doctors close to you.** Blue View Vision has 50,000 eye doctors and locations in its network. If you don't already have a favorite, you can quickly find one. Plus, many retail locations, like LensCrafters®, Target® Optical, and Pearle Vision®, are covered by the plan. Finding a Blue View Vision network provider is easy — simply visit anthem.com.
- **You can get an eye exam every year.** Blue View Vision helps pay for eye exams annually.
- **Not many plans are this simple.** Just schedule an appointment with a network provider and present your member ID card when you arrive. The doctor's office staff will take care of the rest.
- **You save even more with additional discounts.** Want a frame that costs more than your plan allows? You save 20 percent off the balance. Want spare glasses, contact lenses or prescription sunglasses? Save 15 to 40 percent. Your additional discounts are unlimited — even after your vision care benefits have exhausted.

What happens if you use an eye professional not in the network?

You're still covered. You'll be asked to pay the full cost for services at the time of your appointment. When you mail in your receipt and other paperwork to Anthem, you'll get paid back for what the plan covers. To save the most money and have less hassle, try to use an eye doctor or retail location in the network.

This is a brief overview of your plan's features. Your summary of benefits contains the details.

WELCOME TO BLUE VIEW VISION!

This summary outlines the basic components of your vision plan, including quick answers about what's covered, your discounts and much more!

Anthem

Henrico County General Government and Schools

Blue View Vision℠ Exam Only A15 Plan

Your Blue View Vision network
Blue View Vision offers 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®, Target Optical®, and most Pearle Vision® locations. Best of all – when receiving care from a Blue View Vision participating provider, you can maximize benefits and money-saving discounts.

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam - once every calendar year	$15 copay, then covered in full	$30 allowance
Retinal Imaging - at member's option can be performed at time of eye exam	Discounted member cost up to $39	Discount not available
Contact lens fitting and follow-up - a contact lens fitting and two follow-up visits are available once a comprehensive eye exam has been completed.		
Standard contact lens fitting[1]	Covered in full	$35
Premium contact lens fitting[2]	10% off retail price, then apply $55 allowance	$35

ADDITIONAL SAVINGS ON EYEWEAR AND MORE
Blue View Vision members can take advantage of valuable discounts through our Additional Savings program. When visiting a participating Blue View Vision eye care professional or vision center, you can enjoy 35% off the retail price of eye glass frames and 15% off the retail price of conventional (non-disposable) contact lenses. You can also save 20% off the retail price of non-prescription sunglasses and eye care accessories. Plus you'll get special member savings on standard eyeglass lenses, lens treatment options and upgrades. Restrictions may apply and discounts are subject to change without notice.

OUT-OF-NETWORK
If you choose, you can receive care outside of the Blue View Vision network. You simply get an allowance toward your covered services and you pay the rest. In-network benefits and discounts will not apply. When visiting an out-of-network provider, you are responsible for payment of services at the time of service. If you choose an out-of-network provider, you will need to complete the out-of-network claim form and submit it along with your itemized receipt via any of the following methods:

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

EXCLUSIONS & LIMITATIONS
This is a primary vision care benefit and is intended to cover only eye examinations. If medical treatment of the eyes is needed, you should visit a participating eye care physician from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

Combined Offers. Not combined with any offer, coupon, or in-store advertisement.
Experimental or Investigative. Any experimental or investigative services.
Uninsured. Services received before insured person's effective date or after coverage ends.
Excess Amounts. Any amounts in excess of covered vision expense.
Eyewear. Any type of eyewear and related materials including eyeglass lenses, frames, or contact lenses.
Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment.
Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.
Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free.
Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage.
Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
Hospital Care. Inpatient or outpatient hospital vision care.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.
Crime or Nuclear Energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available.

[1]A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[2]A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

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. Frame discounts associated with this vision plan may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice.

Health, wellness & Anthem advantages

Get the most out of your health plan

anthem.com

Clear. Intutive. Easy.

Save money and live better with tools that keep you informed, in control, and at your healthy best.

Health and wellness

Now it's easier than ever to improve your health and well-being. Simply visit anthem.com and login to your account to have access to an array of innovative tools to help you manage your health and achieve your goals.

Health Assessment
Your first step toward a healthier lifestyle

Gain personal insights into your current health, your health risks, and what you can do to enjoy a healthier life. You complete a confidential assessment of your health and health care status, then receive a health assessment score and risk profile based on your specific answers. You also get tips and actions to help you improve your health.

To use the Health Assessment:

- Visit anthem.com
- Click on "Health & Wellness"
- Select "Take my HA now"

Health Record
Your health history in one secure location

Keep your medical records organized, secure and easily accessible for emergencies and everyday use. Enter your information such as dates of immunizations, tests and screenings, prescription and over-the-counter drugs you take, medical conditions and more. Print and share with your doctors to help avoid potential drug interactions and duplicative tests and procedures.

To use Health Record:

- Log in at anthem.com
- Click on "Health & Wellness"
- Under Health Assessment, select "Start your Health Record"

LiveHealth Online

With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of board-certified doctors.
- Private, secure and convenient online visits.
- Members who register, pay a $59 fee. This goes toward your deductible if you haven't met it. If you have met your deductible, the plan pays 80% and you pay 20% of the $59 fee.

To enroll, download the free app on your mobile device and complete the About You page. Or sign up on your computer at livehealthonline.com.

Get the most out of your health plan

LiveHealth Online Psychology
An easy, convenient way to see a therapist or psychologist in just a few days.

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using **LiveHealth Online Psychology**. It's easy to use, private and, in most cases, you can see a therapist within four days or less. All you have to do is sign up at **livehealthonline.com** or download the app to get started. The cost is similar to what you'd pay for an office therapy visit.

Make your first appointment — when it's easy for you

- Use the app or go to **livehealthonline.com** and log in. Select
- **LiveHealth Online Psychology** and choose the therapist you'd like to see. Or, call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m. You'll get an email confirming your appointment.
- You pay the following:
  Costs are $95 for a session with a PhD Psychologist and $80 for a session with a Licensed Social worker. This goes toward your deductible if you haven't met it. If you have met your deductible, the plan pays 80% and you pay 20% of these amounts.

Note: Appointments subject to availability of a therapist.

Special Offers
Discounts on health-related products and services

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids, and audiology services, fitness center memberships, weight-loss programs and more.

To access all discounts:

- Log in at anthem.com
- See the tab for "Discounts"
- Click on that "Discounts" tab

Patient Ratings & Reviews
Doctor recommendations from your peers

Picking a doctor is one of the most important choices you make for your health care. When you find the right one, it can make all the difference in the world and lead to better care and better health. Use our improved Patient Ratings & Reviews tool to see ratings and comments from other patients who have seen a doctor. It can help you make the right choice for you.

Patient Ratings and reviews can be found on anthem.com. Choose Find a Doctor, search for a doctor, and see what ratings are available and what others have to say.

Not registered at anthem.com?
Sign up now for access to personalized service and resources. It's fast, easy and secure.

Health and Wellness programs

The programs you read about here come with your health plan. There is no extra cost for them.

To learn more about these programs online, log in to anthem.com and click on MyHealth@Anthem.

Take charge of your health and the choices you make

We all have different health needs. Maybe you're fit and want to stay that way. Maybe you're living with a chronic condition like asthma. Or maybe you fall somewhere in between. No matter where you fall, our Health and Wellness programs are here to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, we can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

24/7 NurseLine

Within the Emergency and urgent care section, we told you about the 24/7 NurseLine that comes with your plan to help you with any health care decisions you need to make, any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach 24/7 NurseLine, call 1-800-337-4770.

Future Moms

We know your goal is to have a safe delivery and a healthy baby. That's why we offer Future Moms, a voluntary program to help you take care of your baby before you deliver. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues.
- A helpful book: Your Pregnancy Week by Week
- Tips and facts to help you handle any unexpected events
- A questionnaire to see if you're at risk for preterm delivery
- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risk

Enroll in Future Moms by calling 866-664-5404.

Health and Wellness programs

ConditionCare

If you or someone you love has an ongoing illness or health problem, let us help you get more out of life. Our ConditionCare nurses help people of all ages take care of the symptoms of asthma and diabetes. And they work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease. With ConditionCare you'll get the information you need to help you feel your very best. Our ConditionCare nurses gather information from you and your doctor. Then they create a personalized plan for you.

Information and support are as close as your phone. To speak to a ConditionCare Nurse, just call 800-445-7922.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

It's hard enough remembering all the big events in your life. Taking care of your health? That's easy to forget, but there's a program that can help. MyHealth Advantage connects your claims, doctor reports, personal health history and other information for a bigger picture of your health. If we see things you can act on to help improve your health or save money, you'll get a MyHealth Note — a confidential health summary. The program can help you keep health issues from developing or becoming serious. And that means lower health care costs down the road.

MyHealth Notes are mailed to you, or you can read our "suggestions" on your iPhone or Android device by downloading the Anthem Anywhere app. With this app, you have the option of getting personalized health messages on the go via the Secure Message Center.

Healthy Lifestyles

Healthy Lifestyles is a free online program that gives you support and rewards to help you stay healthy or get healthier. Whether you want to quit smoking, lose weight, eat right, exercise more or manage stress, Healthy Lifestyles makes it easy to set goals, track your progress and earn rewards. With Healthy Lifestyles, you can:

- Sign up for a program to quit smoking
- Use nutrition and fitness trackers
- Find healthy recipes
- Join community and online forums
- Get discounts on massages, gym memberships, spa services and more

A healthier lifestyle can be just a mouse click away. To learn more, visit anthem.com.

Information you should know

Managing your care if you need to go to a hospital or get a specific medical treatment

If you or a family member needs a certain type of medical care (for example: surgery, a treatment done in a doctor's office, physical therapy, etc.), you may want to know more about the following programs and definitions. They may help you better understand how your benefits work and how your health plan manages your care in these types of situations.

Utilization Management

Utilization Management (UM) is a program that is part of your health plan that lets us make sure you're getting the right care at the right time. Our UM program is made up of a team of licensed health care professionals such as nurses and doctors who do medical reviews. The UM review team goes over the information we have received from your doctor or other health care provider to see if a surgery, treatment or other type of care that has been requested is medically needed. The UM review team checks to make sure that the treatment meets specific rules set by your health plan. After reviewing the records and information, the surgery or treatment will be approved (covered) or denied (not covered) and the UM review team will let you and your doctor know as soon as possible.

Medical reviews like this can be done before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before medical care is given)
A prospective review is done before a member goes to the hospital or has some other type of service or treatment.

Here are some types of medical needs members may have that might call for a prospective review:

- To go to (and/or stay at) a hospital
- An outpatient procedure (the member can go home the same day)
- Tests done to try to find the cause of an illness such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans
- A certain type of outpatient therapy such as physical therapy or emotional health counseling
- "Durable medical equipment" (DME) which means wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)
A concurrent review is done at the time the member is in the hospital or is released and needs more care related to the hospital stay. This could mean services or treatment done in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment (see above), staying in a nursing home, getting emotional health care and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

Managing your care if you need to go to a hospital or get a specific medical treatment

The retrospective or post-service review (done after medical care is given)
A retrospective review is done when a member has already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at the member's medical information that the doctor or provider had at the time the medical care was given. They can then see if the treatment was medically needed.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions, and help you better understand your health benefits.

Your rights and responsibilities as an Anthem KeyCare member

As an Anthem KeyCare member, you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights." Knowing these rights and responsibilities helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Have privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

Your rights and responsibilities as an Anthem KeyCare member (continued)

You have the responsibility to:

- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Member Services department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your

dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

We may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Important legal information you should take time to read (continued)

Call Member Services at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Member Services at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Important legal information you should take time to read

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: **Anthem Blue Cross and Blue Shield**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Once you're a member, it's easy to get answers to any questions about your plan.

Just call the number on the back of your member identification (ID) card after you get it.

Visit us online at anthem.com

Rev 09/20

County of Henrico
General Government

HCPS
Henrico County Public Schools

Anthem