



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

Frequently asked questions (FAQ)

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

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

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

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

- Check on your claims.
- Find a doctor.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.

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

How can Anthem help me save money?

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

At [anthem.com](https://www.anthem.com), you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products. You can even print your own coupons for healthier groceries.



The ins and outs of coverage

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

But part of your decision in choosing a plan also requires understanding:

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

Who can be enrolled

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

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

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

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

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

renewed	canceled	changed	when . . .
•			Your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	•		Your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	•		We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		•	Your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Lumenos coverage.

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

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



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Special enrollment periods

Typically, you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is first offered to you as a "new hire" or during your employer's open enrollment period when employees can make changes to their benefits for an upcoming year. But there may be instances other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage. But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents.

However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

When you're covered by multiple plans

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

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



The ins and outs of coverage

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Determining the primary versus secondary carrier

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

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



The ins and outs of coverage

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How benefits apply when Medicare-eligible

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

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

Recovery of overpayments

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

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



The ins and outs of coverage

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

Acts of war, disasters, or nuclear accidents

In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

- Bioenergetic synchronization technique (BEST)
- Iridology-study of the iris
- Auditory integration therapy (AIT)
- Colonic irrigation
- Magnetic innervation therapy
- Electromagnetic therapy
- Neurofeedback/Biofeedback

Administrative charges:

- Charges to complete claim forms
- Charges to get medical records or reports
- Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results

Applied behavioral treatment, including but not limited to applied behavioral analysis and intensive behavior interventions for all indications unless otherwise required by law.

Before effective date or after termination date

Charges for care you get before your Effective Date or after your coverage ends.

Alternative/complementary medicine:

- Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - Acupuncture
 - Holistic medicine
 - Homeopathic medicine
 - Hypnosis
 - Aroma therapy
 - Massage and massage therapy
 - Reiki therapy
 - Herbal, vitamin or dietary products or therapies
 - Naturopathy
 - Thermography
 - Orthomolecular therapy
 - Contact reflex analysis

Certain providers

Services from providers that are not licensed by law to provide Covered Services. Examples include but are not limited to masseurs or masseuses (massage therapists), physical therapist technicians and athletic trainers.

Charges over the maximum allowed amount

Charges over the Maximum Allowed Amount for Covered Services.

Charges not supported by medical records

Charges for services not described in your medical records.

Clinically equivalent drugs

Certain prescription drugs if you could use a **clinically equivalent drug**, unless required by law. If you have questions about whether a certain drug is covered and which drugs fall



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into this group, visit our website at anthem.com. If you or your doctor believes you need to use a different prescription drug, please have your doctor get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

Complications of non-covered services

Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

Contraceptives

Contraceptive devices including diaphragms, intrauterine devices (IUDs) and implants (for employers who qualify to opt out of this benefit).

Cosmetic services:

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

- This Exclusion does not apply to:
 - Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
 - Surgery or procedures to correct congenital abnormalities that cause functional impairment.
 - Surgery or procedures on newborn children to correct congenital abnormalities

Court-ordered testing

Court-ordered testing or care unless Medically Necessary.

Custodial care

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

Delivery charges for the delivery of prescription drugs.

Dental exclusions:

- Dental care for Members age 19 and older unless covered by the medical benefits of this plan.
- Dental services or health care services not specifically listed as covered (including any hospital charges, prescription drug charges and dental services and supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this plan.
- Services of anesthesiologists, unless covered by law.
- Anesthesia services (such as intravenous and non-intravenous conscious sedation, analgesia and general anesthesia) are not covered when given separate from a covered oral surgery except as required by law.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain; includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, and gnathologic recordings
- Occlusal procedures.
- Dental services provided solely for the purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Bacteriologic tests for determination of periodontal disease or pathologic agents unless covered by the medical benefits of this Plan.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Collection of oral cytology sample via scraping of the oral mucosa unless covered by the medical benefits of this Plan.



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- Separated services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Incomplete services where the final permanent appliance (denture, partial bridge) or restoration (crown, filling) has not been placed.
- Additional, elective or enhanced prosthodontic procedures including but not limited to: connector bar(s), stress breakers and precision attachments.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from restoration procedure (such as a filling).
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.
- Removal of pulp debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials and the procedures used to prepare and place materials in the canals tooth root.
- Root canal construction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- For dental services received prior to the effective date of this Plan or received after the coverage under this Plan has ended.
- Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
- Implant services, including maintenance or repair to an implant or implant abutment.
- Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.



Experimental ... or not?

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

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



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Drugs over the quantity or age limits

Drugs in quantities which are over the limits set by us or which are over any age limits set by us.

Drugs over the quantity prescribed or refills over one year

Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.

Drugs prescribed by providers lacking qualifications/certifications

Prescription drugs prescribed by a provider who does not have the necessary qualifications, including certifications, as determined by us.

Drugs that do not need a prescription

Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin

Educational services

Services or supplies for teaching, vocational, or self-training purposes.

Experimental or investigational services

Services or supplies that we find are Experimental/Investigational. This also applies to services related to Experimental/Investigational services, whether you get them before, during, or after you get the Experimental/Investigational service or supply. The fact that a service or supply is the only available treatment will not make it a Covered Service if we conclude it is Experimental/Investigational.

Eyeglasses and contact lenses

Eyeglasses and contact lenses to correct your eyesight unless listed as covered. This Exclusion does not apply to lenses needed after a covered eye surgery.

Eye exercises

Orthoptics and vision therapy.

Eye surgery

Eye surgery to fix errors of refraction, such as nearsightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

Family Members

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

Foot care

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

- Cleaning and soaking the feet.
- Applying skin creams to care for skin tone.
- Other services that are given when there is not an illness, injury or symptom involving the foot.

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

Foot orthotics

- Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.

Foot surgery

- Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

Free care

Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics. If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.



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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.

Health club memberships and fitness services

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

Hearing aids

Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered. This exclusion does not apply to cochlear implants.

Home care:

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
- Food, housing, homemaker services, and home delivered meals.

Infertility treatment

Treatment related to infertility.

Refills of **lost or stolen drugs**.

Maintenance therapy

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

This exclusion does not apply to habilitative services.

Medical equipment, devices and supplies:

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

- Non-Medically Necessary enhancements to standard equipment and devices.
- Supplies, equipment and appliances that include comfort, luxury or convenience items or features that exceed what is medically necessary for a member's situation. Reimbursement will be based on the maximum allowable amount for a standard item that is a covered service, serves the same purpose and is medically necessary. Any expense that exceeds the maximum allowable amount for the standard item which is a covered service will be the member's responsibility.

Medicare

Services for which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B except as required by the federal law. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out-of-pocket costs.

Missed or canceled appointments

Charges for missed or canceled appointments.

Non-medically necessary services

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

Nutritional or dietary supplements

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

Off label use

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



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Out-of-network care

Services from a provider who is not in our network. This does not apply to emergency care, urgent care or authorized services (this exclusion applies to Anthem HealthKeepers POS members only).

Oral surgery

Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth.

Personal care and convenience:

- Items for personal comfort, convenience, protection or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
- Home workout or therapy equipment, including treadmills and home gyms.
- Pools, whirlpools, spas, or hydrotherapy equipment.
- Hypoallergenic pillows, mattresses, or waterbeds
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

Prescription benefit exclusions:

- Certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit.
- Administration charges:
 - Charges for the administration of any Drug except for covered immunizations as approved by us or the (PBM).
- Compound drugs:

– Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source non-proprietary vehicles and/or pharmaceutical adjuvants.

- Contraceptives, injectable drugs and patches unless we must cover them by Law (this exclusion only applies if employer group has qualified to opt out of this coverage).
- Contrary to approved medical and professional standards:
 - Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery charges:
 - Charges for delivery of Prescription Drugs.
- Drugs given at the provider's office/facility:
 - Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
- Drugs not on the Anthem prescription drug list (a formulary):
 - You can get a copy of the list by calling us or visiting our website at anthem.com. If you or your doctor believes you need a certain prescription drug not on the list, please refer to the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" section of your post enrollment *Evidence of Coverage* (Anthem HealthKeepers members) or *Member Booklet* (all other members) for details about requesting an exception.
- Drugs that do not need a prescription:



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- Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- Drugs over quantity or age limits:
 - Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
- Drugs over the quantity prescribed or refills after one year:
 - Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
 - Drugs prescribed by providers lacking qualifications/certification: Prescription drugs prescribed by a provider who does not have the necessary qualifications, including certifications, as determined by us.
- Gene therapy:
 - 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.
- Infertility drugs:
 - Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- Items covered as durable medical equipment (DME):
 - Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the “Durable Medical Equipment and Medical Devices” benefit.
- Items covered under the “Allergy Services” benefit:
 - Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit.
- Lost or stolen drugs:
 - Refills of lost or stolen Drugs.
- Home delivery providers other than the PBM's Home Delivery Mail-Order Provider:
 - Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
- Non-approved drugs:
 - Drugs not approved by the FDA.
- Off-label use:
 - Off-label use, unless we must cover the use by law or if we, or the PBM, approve it.
- Onychomycosis drugs:
 - Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-counter items:
 - Drugs, devices and products available over-the-counter. This exclusion does not apply to over-the-counter products that we must cover as a preventive care benefit under federal law with a prescription.
- Sexual dysfunction drugs:
 - Drugs to treat sexual or erectile problems.
- Syringes:
 - Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight loss drugs:
 - Any Drug mainly used for weight loss.



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Private-duty nursing

Private-duty Nursing Services. Your coverage does not include benefits for private-duty nurses in the inpatient setting.

Prosthetics

Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.

Residential accommodations

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

Sexual dysfunction

Services or supplies for male or female sexual problems.

Stand-by charges

Stand-by charges of a Doctor or other Provider.

Reversal of elective sterilization (for employer groups who qualify to opt out)

Sterilization for females (for employer groups who qualify to opt out)

Surrogate mother services

Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Telemedicine

Non-interactive telemedicine services, such as audio only telephone conversations, electronic mail messages, fax transmissions or online questionnaires.

Temporomandibular joint treatment

Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

Travel costs

Mileage, lodging, meals, and other Member-related travel costs.

Vein treatment

Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

Vision services:

- Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this *Booklet*.
- Safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- Plano lenses (lenses that have no refractive power)
- Lost or broken lenses or frames unless the member reached their normal interval for service when seeking replacements.
- Vision services not listed as covered in this *Booklet*.
- Cosmetic lenses or options, such as special lens coating or non-prescription lenses, unless specifically listed as covered.
- Blended lenses.
- Oversize lenses.
- Sunglasses and accompanying frames.
- For services or supplies combined with any other offer, coupon or in-store advertisement or for certain brands of frames where the manufacturer does not allow discounts.
- For or vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not permitted by a licenses provider.



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Waived cost shares out-of-network

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

Weight loss programs

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

Weight loss surgery bariatric surgery

This includes, but is not limited to, Roux-en-Y (RNY) Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries that lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty (surgeries that reduce stomach size) or gastric banding procedures.



Let's talk about your privacy and rights

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

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

How we help manage your care

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

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you

learn about and manage your health conditions. They also help you better understand your health benefits.

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



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



And Its Affiliate HealthKeepers, Inc.

These policies have exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans: ABCBS-VA-PPO-COC (1/17), ABCBS-VA-PPO-SOB-TVA1G3 (1/17), ABCBS-VA-PPO-SOB-TVA1G17 (1/17), ABCBS-VA-PPO-SOB-TVA1P100 (1/17), ABCBS-VA-PPO-SOB-TVA1P101 (1/17), ABCBS-VA-PPO-SOB-TVA1P3 (1/17), ABCBS-VA-PPO-SOB-TVA2-RG11 (1/17), ABCBS-VA-PPO-SOB-TVA2-RG38 (1/17), ABCBS-VA-PPO-SOB-TVA2-RG63 (1/17), ABCBS-VA-PPO-SOB-TVA2-RG64 (1/17), ABCBS-VA-PPO-SOB-TVA2-RG65 (1/17), ABCBS-VA-PPO-SOB-TVA2-RG66 (1/17), ABCBS-VA-PPO-SOB-TVA2-RS5 (1/17), ABCBS-VA-PPO-SOB-TVA2-RS15 (1/17), ABCBS-VA-PPO-SOB-TVA3G4-PrevRx (1/17), ABCBS-VA-PPO-SOB-TVA3G7-PrevRx (1/17), ABCBS-VA-PPO-SOB-TVA3G1-rxF (1/17), ABCBS-VA-PPO-SOB-TVA3S2-HSA-rxC-PrevRx (1/17), ABCBS-VA-PPO-SOB-TVA3S3-HSA-rxC-PrevRx (1/17), ABCBS-VA-PPO-SOB-TVA3S30-HSA-PrevRx (1/17), ABCBS-VA-PPO-SOB-TVA3S6-HSA-PrevRx (1/17). The enrollment application used with these plans is 37612VAMENABS (1/17).

If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. Life and Disability products underwritten by Anthem Life Insurance. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

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

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