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 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)

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

renewed	cancelled	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 coverage.

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

renewed	cancelled	when ...
●		you maintain your eligibility for coverage with your employer, pay your required portion of the health care cost 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.

The ins and outs of coverage (continued)

Special enrollment periods

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

How we establish our rates

Factors used to set the price of health care coverage for employers with 2-99 employees:

- your employer's location
- age of each family member with one age band for members age 0 to 20, an age band for members age 21-63 and one age band for members age 64+
- members' use of tobacco four or more times per week

When you're covered by multiple plans

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

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

The ins and outs of coverage (continued)

Determining the primary versus secondary carrier

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

When a person is covered by 2 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 non-custodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

The ins and outs of coverage (continued)

How benefits apply when Medicare-eligible

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

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

The ins and outs of coverage (continued)

What's not covered (exclusions)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them 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.

1. **Acts of War, Disasters, or Nuclear Accidents**
   In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

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

3. **Alternative / Complementary Medicine**
   Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

   a) Acupuncture.
   b) Holistic medicine.
   c) Homeopathic medicine.
   d) Hypnosis.
   e) Aroma therapy.
   f) Massage and massage therapy.
   g) Reiki therapy.
   h) Herbal, vitamin or dietary products or therapies.
   i) Naturopathy.
   j) Thermography.
   k) Orthomolecular therapy.
   l) Contact reflex analysis.
   m) Bioenergial synchronization technique (BEST).
   n) Iridology-study of the iris.
   o) Auditory integration therapy (AIT).
   p) Colonic irrigation.
   q) Magnetic innervation therapy.
   r) Electromagnetic therapy.
   s) Neurofeedback / Biofeedback.

4. **Before Effective Date or After Termination Date**
   Charges for care you get before your Effective Date or after your coverage ends.

5. **Charges Over the Maximum Allowed Amount**
   Charges over the Maximum Allowed Amount for Covered Services.

6. **Charges Not Supported by Medical Records**
   Charges for services not described in your medical records.

The ins and outs of coverage (continued)

7. **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.

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

   This Exclusion does not apply to:

   a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
   b) Surgery or procedures to correct congenital abnormalities that cause functional impairment.
   c) Surgery or procedures on newborn children to correct congenital abnormalities The Plan will not consider the patient's mental state in deciding if surgery is cosmetic.

9. **Court Ordered Testing**
   Court ordered testing or care unless Medically Necessary.

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

11. **Dental Exclusions**
    Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

    a) Removing, restoring, or replacing teeth.
    b) Medical care or surgery for dental problems.
    c) Services to help dental clinical outcomes.

    Dental treatment for injuries that are a result of biting or chewing is also excluded. This Exclusion does not apply to services that we must cover by law.

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

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

The ins and outs of coverage (continued)

13. **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.
14. **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.
15. **Eye Exercises**
    Orthoptics and vision therapy.
16. **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.
17. **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.
18. **Foot Care**
    Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

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

    This exclusion does not apply to the treatment of corns, calluses, and care of toenails for members with diabetes or vascular disease.
19. **Foot Orthotics**
    Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.
20. **Foot Surgery**
    Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
21. **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.
22. **Hearing Aids**
    Hearing aids or exams to prescribe or fit hearing aids. This Exclusion does not apply to cochlear implants.
23. **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.

These services are not covered by your plan.

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24. **Home Care**
    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
    b) Food, housing, homemaker services, and home delivered meals.
25. **Infertility Treatment**
    Treatment related to infertility.
26. **Maintenance Therapy**
    Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.
27. **Medical Equipment and Supplies**
    a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    c) Non-Medically Necessary enhancements to standard equipment and devices.
28. **Medicare**
    Services for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B and/or D, 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.
29. **Missed or Canceled Appointments**
    Charges for missed or canceled appointments.
30. **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.
31. **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.
32. **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.
33. **Personal Care and Convenience**
    a) Items for personal comfort, convenience, protection or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
    b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
    c) Home workout or therapy equipment, including treadmills and home gyms.
    d) Pools, whirlpools, spas, or hydrotherapy equipment.
    e) Hypo-allergenic pillows, mattresses, or waterbeds,
    f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

These services are not covered by your plan.

The ins and outs of coverage (continued)

34. Prescription Benefit Exclusions
Certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

a) **Administration Charges**
Charges for the administration of any Drug except for covered immunizations as approved by us or the (PBM).

b) **Compound Drugs**
Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.

c) **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.

d) **Delivery Charges**
Charges for delivery of Prescription Drugs.

e) **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.

f) **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.

g) **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. 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.

h) **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.

i) **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.

j) **Fluoride Treatments**
Topical and oral fluoride treatments.

k) **Infertility Drugs**
Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)

l) **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.

m) **Items Covered as Medical Supplies**
Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.

The ins and outs of coverage (continued)

n) **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.

o) **Lost or Stolen Drugs**
Refills of lost or stolen Drugs.

p) **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider**
Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.

q) **Non-approved Drugs**
Drugs not approved by the FDA.

r) **Off-label Use**
Off-label use, unless we must cover the use by law or if we, or the PBM, approve it.

s) **Onychomycosis Drugs**
Drugs for Onchomycosis (toenail fungus) except when we allow it to treat Members who are immuno- compromised or diabetic.

t) **Over-the-Counter Items**
Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.

u) **Sex Change Drugs**
Drugs for sex change surgery.

v) **Sexual Dysfunction Drugs**
Drugs to treat sexual or erectile problems.

w) **Syringes**
Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

x) **Weight Loss Drugs**
Any Drug mainly used for weight loss.

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

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

37. **Providers**
Services you get from a non-covered Provider. Examples of non-covered Providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

38. **Residential Treatment Centers**
This exclusion does not apply when such setting qualifies as a substance use disorder treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care.

39. **Sex Change**
Services and supplies for a sex change and/or the reversal of a sex change.

40. **Sexual Dysfunction**
Services or supplies for male or female sexual problems.

41. **Stand-By Charges**
Stand-by charges of a Doctor or other Provider.

These services are not covered by your plan.

The ins and outs of coverage (continued)

42. **Reversal of Elective Sterilization**

43. **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).

44. **Telemedicine**
    Non-interactive telemedicine services, such as audio- only telephone conversations; electronic mail message or fax transmissions.

45. **Temporomandibular Joint Treatment**
    Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

46. **Travel Costs**
    Mileage, lodging, meals, and other Member-related travel costs.

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

48. **Vision Services**
    a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
    b) Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.
    c) Safety glasses and accompanying frames.
    d) For two pairs of glasses in lieu of bifocals.
    e) Plano lenses (lenses that have no refractive power)
    f) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
    g) Vision services not listed as covered in this Booklet.
    h) Cosmetic lenses or options.
    i) Blended lenses.
    j) Oversize lenses.
    k) Sunglasses and accompanying frames.
    l) For services or supplies combined with any other offer, coupon or in-store advertisement.
    m) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
    n) Certain frames in which the manufacturer imposes a no discount policy

49. **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.

50. **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.