Virginia

Effective January 1, 2021

Small Group ACA medical product guide

Anthem | SMALL BUSINESS

And Its Affiliate HealthKeepers, Inc.

101152VAEENBVA 6/20

Small Group ACA product details – 1 to 50 employees

The plan naming structure includes these elements:

Anthem + metal tier + [network name] + product type + copay or deductible/coinsurance/out-of-pocket maximum

The below overview represents in-network benefits. For more plan information, please refer to the Summary of Benefits (SOB). To find a specific SOB for any of these plans, visit **plan-summaries.anthem.com/sobdps/**.

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Anthem Link Blue Connection (Blue HPN) EPO plans

Primary care, LiveHealth Online and retail health clinics covered in full (no member cost share).

With the Blue Connection High-Performance Network (Blue HPN), members receive in-network coverage when they visit any participating HPN provider in our HPN service areas across the U.S. Out-of-network and out of country coverage is limited to urgent and emergency care. To find Blue Connection (Blue HPN) providers, visit *anthem.com/find-care/* or ask your Anthem representative for details.

	Platinum plans	Gold plans			Silver plans
Plan type	EPO				
Plan name	Anthem Link Platinum Blue Connection OAEPO 500/20%/2500Ω	Anthem Link Gold Blue Connection OAEPO 1000/20%/8000Ω	Anthem Link Gold Blue Connection OAEPO 2000/20%/5000Ω	Anthem Link Gold Blue Connection OAEPO 3000/20%/6000Ω	Anthem Link Silver Blue Connection OAEPO 7000/30%/8400Ω
Network	Blue Connection	Blue Connection	Blue Connection	Blue Connection	Blue Connection
Contract code[1]	5L8R	5L8T	5L8V	5L8X	5L8Z
Deductible[2] (individual/family)	$500/$1,500	$1,000/$3,000	$2,000/$4,000	$3,000/$6,000	$7,000/$14,000
Coinsurance	20%	20%	20%	20%	30%
Out-of-pocket maximum (individual/family)	$2,500/$5,000	$8,000/$16,000	$5,000/$10,000	$6,000/$12,000	$8,400/$16,800
Office visits: EPHC[3]	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	PCP: Covered in full SPC: $75 RHC: Covered in full	PCP: Covered in full SPC: $75 RHC: Covered in full	PCP: Covered in full SPC: $75 RHC: Covered in full	PCP: Covered in full SPC: $75 RHC: Covered in full	PCP: Covered in full SPC: $75 RHC: Covered in full
Online doctor visits: LiveHealth Online[5]	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Urgent care (facility)	$100	$100	$100	$100	$100
Emergency room (facility)[6]	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Independent facility: ambulatory outpatient surgery center	$500	$500	$500	$500	$500
Independent facility: X-ray and ultrasound	$75	$75	$75	$75	$75
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	$250	$250	$250	$250	$250
Hospital outpatient surgery facility	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	$15/$50/$90/$400	$15/$50/$90/$400	$15/$50/$90/$400	$15/$50/$90/$400	$15/$50/$90/$400

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.

‡ For plans with a PreventiveRx benefit, the deductible will be waived for Tiers 1 and 2, then the applicable copay/coinsurance applies.

1 Please see benefit proposal for final contract code. Plan year (PY) and Calendar year (CY) contracts share the same contract code.

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KeyCare PPO plans

	Platinum plans			Gold plans			
Plan type	PPO						
Plan name	Anthem Platinum PPO 10/0%/3500Ω	Anthem Platinum PPO 250/10%/4000Ω	Anthem Platinum PPO 500/10%/4500Ω	Anthem Gold PPO 20/0%/5500Ω	Anthem Gold PPO 25/20%/6000Ω	Anthem Gold PPO 30/30%/6500Ω	Anthem Gold PPO 750/20%/7700Ω
Network	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare
Contract code[1]	5L6R	5L6H	5L6M	5L7T	5L85	5L7M	5L6T
Deductible[2] (individual/family)	$0/$0	$250/$750	$500/$1,500	$0/$0	$0/$0	$0/$0	$750/$2,250
Coinsurance	0%	10%	10%	0%	20%	30%	20%
Out-of-pocket maximum (individual/family)	$3,500/$7,000	$4,000/$8,000	$4,500/$9,000	$5,500/$11,000	$6,000/$12,000	$6,500/$13,000	$7,700/$15,400
Office visits: EPHC[3]	$10	$10	$15	$10	$15	$20	$15
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	PCP: $10 SPC: $30 RHC: $10	PCP: $15 SPC: $35 RHC: $15	PCP: $25 SPC: $50 RHC: $25	PCP: $20 SPC: $60 RHC: $20	PCP: $25 SPC: $60 RHC: $25	PCP: $30 SPC: $50 RHC: $30	PCP: $25 SPC: $60 RHC: $25
Online doctor visits: LiveHealth Online[5]	$0	$10	$10	$10	$10	$15	$10
Urgent care (facility)	$30	$35	$50	$60	$60	$50	$60
Emergency room (facility)[6]	$350	Deductible, then $350	Deductible, then $350	$400	$400	$400	Deductible, then $450
Independent facility: ambulatory outpatient surgery center	$200	$400	$400	$250	$250	$200	$400
Independent facility: X-ray and ultrasound	$30	$75	$75	$60	$60	$50	$75
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	$100	$200	$200	$100	$100	$100	$200
Hospital outpatient surgery facility	$300	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	$350	$350	$300	Deductible, then 20% coinsurance
Hospital inpatient admission	$350 copay per day up to 4 days per admission	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	$400 copay per day up to 4 days per admission	$500 copay per day up to 4 days per admission	$500 copay per day up to 4 days per admission	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script

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KeyCare PPO plans

	Gold plans						Silver plans
Plan type	PPO					PPO HSA	PPO
Plan name	Anthem Gold PPO 1000/20%/5500	Anthem Gold PPO 1500/20%/5750Ω	Anthem Gold PPO 1500/30%/6000Ω	Anthem Gold PPO 2000/20%/5250Ω	Anthem Gold PPO 3000/20%/5500Ω	Anthem Gold PPO 2800/10%/5000 w/HSA	Anthem Silver PPO 2250/50%/8550Ω
Network	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare
Contract code[1]	5L6B	5L77	5L79	5L7F	5L8M	5L67	5L73
Deductible[2] (individual/family)	$1,000/$3,000	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000	$3,000/$6,000	$2,800/$5,600	$2,250/$4,500
Coinsurance	20%	20%	30%	20%	20%	10%	50%
Out-of-pocket maximum (individual/family)	$5,500/$11,000	$5,750/$11,500	$6,000/$12,000	$5,250/$10,500	$5,500/$11,000	$5,000/$10,000	$8,550/$17,100
Office visits: EPHC[3]	Not applicable	$15	$10	$20	$25	Not applicable	$40
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	Deductible, then 20% coinsurance	PCP: $25 SPC: $60 RHC: $25	PCP: $20 SPC: $60 RHC: $20	PCP: $30 SPC: $60 RHC: $30	PCP: $35 SPC: $55 RHC: $35	Deductible, then 10% coinsurance	PCP: $50 SPC: $80 RHC: $50
Online doctor visits: LiveHealth Online[5]	Deductible, then 20% coinsurance	$10	$10	$15	$15	Deductible, then 10% coinsurance	$15
Urgent care (facility)	Deductible, then 20% coinsurance	$60	$60	$60	$55	Deductible, then 10% coinsurance	$80
Emergency room (facility)[6]	Deductible, then 20% coinsurance	Deductible, then $400	Deductible, then $350	Deductible, then $400	Deductible, then $350	Deductible, then 10% coinsurance	Deductible, then $400
Independent facility: ambulatory outpatient surgery center	Deductible, then 20% coinsurance	$400	$400	$400	$400	Deductible, then 10% coinsurance	$400
Independent facility: X-ray and ultrasound	Deductible, then 20% coinsurance	$75	$75	$75	$75	Deductible, then 10% coinsurance	$75
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	Deductible, then 20% coinsurance	$200	$200	$200	$200	Deductible, then 10% coinsurance	$200
Hospital outpatient surgery facility	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 50% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 50% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tiers 1-4: Medical deductible applies	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tiers 1-4: Medical deductible applies‡	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	20%	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	20%	$15/$45/25% up to $200 per script/25% up to $400 per script

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KeyCare PPO plans

	Silver plans						
Plan type	PPO		PPO HSA				
Plan name	Anthem Silver PPO 4000/20%/8550Ω	Anthem Silver PPO 5500/20%/8000Ω	Anthem Silver PPO 3250/20%/6750 w/HSA	Anthem Silver PPO 4000/20%/7000 w/HSA	Anthem Silver PPO 4500/20%/7000 w/HSA	Anthem Silver PPO 5000/20%/7000 w/HSA	Anthem Silver PPO 6000/20%/7000 w/HSA
Network	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare	KeyCare
Contract code[1]	5L6X	5L8H	5L7V	5L83	5L5V	5L8D	5L63
Deductible[2] (individual/family)	$4,000/$8,000	$5,500/$11,000	$3,250/$6,500	$4,000/$8,000	$4,500/$9,000	$5,000/$10,000	$6,000/$12,000
Coinsurance	20%	20%	20%	20%	20%	20%	20%
Out-of-pocket maximum (individual/family)	$8,550/$17,100	$8,000/$16,000	$6,750/$13,500	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000
Office visits: EPHC[3]	$30	$35	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	PCP: $40 SPC: $70 RHC: $40	PCP: $45 SPC: $65 RHC: $45	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Online doctor visits: LiveHealth Online[5]	$15	$15	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Urgent care (facility)	$70	$65	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Emergency room (facility)[6]	Deductible, then $400	Deductible, then $400	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Independent facility: ambulatory outpatient surgery center	$400	$400	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Independent facility: X-ray and ultrasound	$75	$75	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	$200	$200	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital outpatient surgery facility	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	$15/$45/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	20%	20%	20%	20%	20%

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	Silver plans	Bronze plans
Plan type	PPO HSA	PPO
Plan name	Anthem Silver PPO 6850/0%/6850 w/HSA	Anthem Bronze PPO 8500/0%/8500
Network	KeyCare	KeyCare
Contract code[1]	5L8B	5L5Z
Deductible[2] (individual/family)	$6,850/$13,700	$8,500/$17,000
Coinsurance	0%	0%
Out-of-pocket maximum (individual/family)	$6,850/$13,700	$8,500/$17,000
Office visits: EPHC[3]	Not applicable	Not applicable
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Online doctor visits: LiveHealth Online[5]	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Urgent care (facility)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Emergency room (facility)[6]	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Independent facility: X-ray and ultrasound	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital outpatient surgery facility	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	0%	0%

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.

‡ For plans with a PreventiveRx benefit, the deductible will be waived for Tiers 1 and 2, then the applicable copay/coinsurance applies.

1 Please see benefit proposal for final contract code. Plan year (PY) and Calendar year (CY) contracts share the same contract code.

2 All plans have **embedded** deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible or OOP maximum amount paid by an individual family member applies to the family deductible/OOP maximum amount, but no individual family member pays more to the family deductible/OOP maximum than their individual deductible/OOP maximum amount.

3 Some plans include a reduced cost share when seeing an Enhanced Personal Health Care provider (EPHC).

4 Specialist (SPC) cost share applies to specialist office and LiveHealth Online (LHO) specialist visits.

5 Cost share applies to LiveHealth Online primary care medical doctor visits and behavioral health (mental health / substance abuse) visits.

6 When a member's plan requires a copay for an emergency room facility visit and the member is then directly admitted to the hospital, the initial emergency room facility visit copay will be waived if the plan includes a copay for hospital admission. If the member's cost share for hospital admission is coinsurance, then the initial emergency room facility copay will not be waived.

7 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

8 Retail pharmacy cost shares apply to a 30-day supply at a retail pharmacy. Members will pay more for up to a 90-day supply at home delivery and Rx 90 retail pharmacies. Specialty drug benefits are covered up to a 30-day supply limit. Any plan that has a pharmacy copay in Tiers 1 and 2 and a coinsurance in Tiers 3 and 4 will have a per script maximum in Tiers 3 and 4. Pharmacy plans with a deductible and coinsurance for Tiers 1 and 2 will not have a per script maximum as part of the Tier 3 and 4 benefit.

Small Group ACA product details – 1 to 50 employees

The plan naming structure includes these elements:

Anthem + metal tier + [network name] + product type + copay or deductible/coinsurance/out-of-pocket maximum

The below overview represents in-network benefits. For more plan information, please refer to the Summary of Benefits (SOB). To find a specific SOB for any of these plans, visit **plan-summaries.anthem.com/sobdps/**.

All product offerings are subject to regulatory review and approval and are subject to change.

HealthKeepers POS plans

	Platinum plans			Gold plans			
Plan type	POS						
Plan name	Anthem HealthKeepers Platinum OAPOS 10/0%/3500Ω	Anthem HealthKeepers Platinum OAPOS 250/10%/4000Ω	Anthem HealthKeepers Platinum OAPOS 500/10%/4500Ω	Anthem HealthKeepers Gold OAPOS 20/0%/5500Ω	Anthem HealthKeepers Gold OAPOS 25/20%/6000Ω	Anthem HealthKeepers Gold OAPOS 30/30%/6500Ω	Anthem HealthKeepers Gold OAPOS 750/20%/7700Ω
Network	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers
Contract code[1]	5L6P	5L6F	5L6K	5L7R	5L87	5L7P	5L6V
Deductible[2] (individual/family)	$0/$0	$250/$750	$500/$1,500	$0/$0	$0/$0	$0/$0	$750/$2,250
Coinsurance	0%	10%	10%	0%	20%	30%	20%
Out-of-pocket maximum (individual/family)	$3,500/$7,000	$4,000/$8,000	$4,500/$9,000	$5,500/$11,000	$6,000/$12,000	$6,500/$13,000	$7,700/$15,400
Office visits: EPHC[3]	$10	$10	$15	$10	$15	$20	$15
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	PCP: $10 SPC: $30 RHC: $10	PCP: $15 SPC: $35 RHC: $15	PCP: $25 SPC: $50 RHC: $25	PCP: $20 SPC: $60 RHC: $20	PCP: $25 SPC: $60 RHC: $25	PCP: $30 SPC: $50 RHC: $30	PCP: $25 SPC: $60 RHC: $25
Online doctor visits: LiveHealth Online[5]	$0	$10	$10	$10	$10	$15	$10
Urgent care (facility)	$30	$35	$50	$60	$60	$50	$60
Emergency room (facility)[6]	$350	Deductible, then $350	Deductible, then $350	$400	$400	$400	Deductible, then $450
Independent facility: ambulatory outpatient surgery center	$200	$400	$400	$250	$250	$200	$400
Independent facility: X-ray and ultrasound	$30	$75	$75	$60	$60	$50	$75
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	$100	$200	$200	$100	$100	$100	$200
Hospital outpatient surgery facility	$300	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	$350	$350	$300	Deductible, then 20% coinsurance
Hospital inpatient admission	$350 copay per day up to 4 days per admission	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	$400 copay per day up to 4 days per admission	$500 copay per day up to 4 days per admission	$500 copay per day up to 4 days per admission	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.

‡ For plans with a PreventiveRx benefit, the deductible will be waived for Tiers 1 and 2, then the applicable copay/coinsurance applies.

1 Please see benefit proposal for final contract code. Plan year (PY) and Calendar year (CY) contracts share the same contract code.

2 All plans have **embedded** deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible or OOP maximum amount paid by an individual family member applies to the family deductible/OOP maximum amount, but no individual family member pays more to the family deductible/OOP maximum than their individual deductible/OOP maximum amount.

3 Some plans include a reduced cost share when seeing an Enhanced Personal Health Care provider (EPHC).

4 Specialist (SPC) cost share applies to specialist office and LiveHealth Online (LHO) specialist visits.

5 Cost share applies to LiveHealth Online primary care medical doctor visits and behavioral health (mental health / substance abuse) visits.

6 When a member's plan requires a copay for an emergency room facility visit and the member is then directly admitted to the hospital, the initial emergency room facility visit copay will be waived if the plan includes a copay for hospital admission. If the member's cost share for hospital admission is coinsurance, then the initial emergency room facility copay will not be waived.

7 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

8 Retail pharmacy cost shares apply to a 30-day supply at a retail pharmacy. Members will pay more for up to a 90-day supply at home delivery and Rx 90 retail pharmacies. Specialty drug benefits are covered up to a 30-day supply limit. Any plan that has a pharmacy copay in Tiers 1 and 2 and a coinsurance in Tiers 3 and 4 will have a per script maximum in Tiers 3 and 4. Pharmacy plans with a deductible and coinsurance for Tiers 1 and 2 will not have a per script maximum as part of the Tier 3 and 4 benefit.

Small Group ACA product details – 1 to 50 employees

The plan naming structure includes these elements:

Anthem + metal tier + [network name] + product type + copay or deductible/coinsurance/out-of-pocket maximum

The below overview represents in-network benefits. For more plan information, please refer to the Summary of Benefits (SOB). To find a specific SOB for any of these plans, visit **plan-summaries.anthem.com/sobdps/**.

All product offerings are subject to regulatory review and approval and are subject to change.

HealthKeepers POS plans

	Gold plans						Silver plans
Plan type	POS					POS HSA	POS
Plan name	Anthem HealthKeepers Gold OAPOS 1000/20%/5500	Anthem HealthKeepers Gold OAPOS 1500/20%/5750Ω	Anthem HealthKeepers Gold OAPOS 1500/30%/6000Ω	Anthem HealthKeepers Gold OAPOS 2000/20%/5250Ω	Anthem HealthKeepers Gold OAPOS 3000/20%/5500Ω	Anthem HealthKeepers Gold OAPOS 2800/10%/5000 w/HSA	Anthem HealthKeepers Silver OAPOS 2250/50%/8550Ω
Network	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers
Contract code[1]	5L6D	5L75	5L7B	5L7D	5L8P	5L69	5L71
Deductible[2] (individual/family)	$1,000/$3,000	$1,500/$3,000	$1,500/$3,000	$2,000/$4,000	$3,000/$6,000	$2,800/$5,600	$2,250/$4,500
Coinsurance	20%	20%	30%	20%	20%	10%	50%
Out-of-pocket maximum (individual/family)	$5,500/$11,000	$5,750/$11,500	$6,000/$12,000	$5,250/$10,500	$5,500/$11,000	$5,000/$10,000	$8,550/$17,100
Office visits: EPHC[3]	Not applicable	$15	$10	$20	$25	Not applicable	$40
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	Deductible, then 20% coinsurance	PCP: $25 SPC: $60 RHC: $25	PCP: $20 SPC: $60 RHC: $20	PCP: $30 SPC: $60 RHC: $30	PCP: $35 SPC: $55 RHC: $35	Deductible, then 10% coinsurance	PCP: $50 SPC: $80 RHC: $50
Online doctor visits: LiveHealth Online[5]	Deductible, then 20% coinsurance	$10	$10	$15	$15	Deductible, then 10% coinsurance	$15
Urgent care (facility)	Deductible, then 20% coinsurance	$60	$60	$60	$55	Deductible, then 10% coinsurance	$80
Emergency room (facility)[6]	Deductible, then 20% coinsurance	Deductible, then $400	Deductible, then $350	Deductible, then $400	Deductible, then $350	Deductible, then 10% coinsurance	Deductible, then $400
Independent facility: ambulatory outpatient surgery center	Deductible, then 20% coinsurance	$400	$400	$400	$400	Deductible, then 10% coinsurance	$400
Independent facility: X-ray and ultrasound	Deductible, then 20% coinsurance	$75	$75	$75	$75	Deductible, then 10% coinsurance	$75
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	Deductible, then 20% coinsurance	$200	$200	$200	$200	Deductible, then 10% coinsurance	$200
Hospital outpatient surgery facility	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 50% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 50% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tiers 1-4: Medical deductible applies	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tiers 1-4: Medical deductible applies‡	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	20%	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$10/$40/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	20%	$15/$45/25% up to $200 per script/25% up to $400 per script

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.

‡ For plans with a PreventiveRx benefit, the deductible will be waived for Tiers 1 and 2, then the applicable copay/coinsurance applies.

1 Please see benefit proposal for final contract code. Plan year (PY) and Calendar year (CY) contracts share the same contract code.

2 All plans have **embedded** deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible or OOP maximum amount paid by an individual family member applies to the family deductible/OOP maximum amount, but no individual family member pays more to the family deductible/OOP maximum than their individual deductible/OOP maximum amount.

3 Some plans include a reduced cost share when seeing an Enhanced Personal Health Care provider (EPHC).

4 Specialist (SPC) cost share applies to specialist office and LiveHealth Online (LHO) specialist visits.

5 Cost share applies to LiveHealth Online primary care medical doctor visits and behavioral health (mental health / substance abuse) visits.

6 When a member's plan requires a copay for an emergency room facility visit and the member is then directly admitted to the hospital, the initial emergency room facility visit copay will be waived if the plan includes a copay for hospital admission. If the member's cost share for hospital admission is coinsurance, then the initial emergency room facility copay will not be waived.

7 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

8 Retail pharmacy cost shares apply to a 30-day supply at a retail pharmacy. Members will pay more for up to a 90-day supply at home delivery and Rx 90 retail pharmacies. Specialty drug benefits are covered up to a 30-day supply limit. Any plan that has a pharmacy copay in Tiers 1 and 2 and a coinsurance in Tiers 3 and 4 will have a per script maximum in Tiers 3 and 4. Pharmacy plans with a deductible and coinsurance for Tiers 1 and 2 will not have a per script maximum as part of the Tier 3 and 4 benefit.

Small Group ACA product details – 1 to 50 employees

The plan naming structure includes these elements:

Anthem + metal tier + [network name] + product type + copay or deductible/coinsurance/out-of-pocket maximum

The below overview represents in-network benefits. For more plan information, please refer to the Summary of Benefits (SOB). To find a specific SOB for any of these plans, visit **plan-summaries.anthem.com/sobdps/**.

All product offerings are subject to regulatory review and approval and are subject to change.

HealthKeepers POS plans

	Silver plans						
Plan type	POS					POS HSA	
Plan name	Anthem HealthKeepers Silver OAPOS 2500/35%/6500Ω	Anthem HealthKeepers Silver OAPOS 3500/30%/5500Ω	Anthem HealthKeepers Silver OAPOS 4000/20%/8550Ω	Anthem HealthKeepers Silver OAPOS 5500/20%/8000Ω	Anthem HealthKeepers Silver OAPOS 6500/0%/8550Ω	Anthem HealthKeepers Silver OAPOS 3250/20%/6750 w/HSA	Anthem HealthKeepers Silver OAPOS 4000/20%/7000 w/HSA
Network	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers
Contract code[1]	5L7Z	5L7K	5L6Z	5L8K	5L7H	5L7X	5L81
Deductible[2] (individual/family)	$2,500/$5,000	$3,500/$7,000	$4,000/$8,000	$5,500/$11,000	$6,500/$13,000	$3,250/$6,500	$4,000/$8,000
Coinsurance	35%	30%	20%	20%	0%	20%	20%
Out-of-pocket maximum (individual/family)	$6,500/$13,000	$5,500/$11,000	$8,550/$17,100	$8,000/$16,000	$8,550/$17,100	$6,750/$13,500	$7,000/$14,000
Office visits: EPHC[3]	Not applicable	Not applicable	$30	$35	Not applicable	Not applicable	Not applicable
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	$45 for first 3 visits, then deductible and 35% coinsurance	$35 for first 3 visits, then deductible and 30% coinsurance	PCP: $40 SPC: $70 RHC: $40	PCP: $45 SPC: $65 RHC: $45	$45 for first 3 visits, then deductible and 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Online doctor visits: LiveHealth Online[5]	$15	$15	$15	$15	$15	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Urgent care (facility)	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance	$70	$65	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Emergency room (facility)[6]	Deductible, then $400	Deductible, then $400	Deductible, then $400	Deductible, then $400	Deductible, then $500	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Independent facility: ambulatory outpatient surgery center	$400	$400	$400	$400	$400	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Independent facility: X-ray and ultrasound	$75	$75	$75	$75	$75	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	$200	$200	$200	$200	$200	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital outpatient surgery facility	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital inpatient admission	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tier 1: No deductible Tiers 2-4: $500/$1,000 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $500/$1,000 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $500/$1,000 Pharmacy deductible	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	$15/$45/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	$15/$45/25% up to $200 per script/25% up to $400 per script	20%	20%

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.

‡ For plans with a PreventiveRx benefit, the deductible will be waived for Tiers 1 and 2, then the applicable copay/coinsurance applies.

1 Please see benefit proposal for final contract code. Plan year (PY) and Calendar year (CY) contracts share the same contract code.

2 All plans have **embedded** deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible or OOP maximum amount paid by an individual family member applies to the family deductible/OOP maximum amount, but no individual family member pays more to the family deductible/OOP maximum than their individual deductible/OOP maximum amount.

3 Some plans include a reduced cost share when seeing an Enhanced Personal Health Care provider (EPHC).

4 Specialist (SPC) cost share applies to specialist office and LiveHealth Online (LHO) specialist visits.

5 Cost share applies to LiveHealth Online primary care medical doctor visits and behavioral health (mental health / substance abuse) visits.

6 When a member's plan requires a copay for an emergency room facility visit and the member is then directly admitted to the hospital, the initial emergency room facility visit copay will be waived if the plan includes a copay for hospital admission. If the member's cost share for hospital admission is coinsurance, then the initial emergency room facility copay will not be waived.

7 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

8 Retail pharmacy cost shares apply to a 30-day supply at a retail pharmacy. Members will pay more for up to a 90-day supply at home delivery and Rx 90 retail pharmacies. Specialty drug benefits are covered up to a 30-day supply limit. Any plan that has a pharmacy copay in Tiers 1 and 2 and a coinsurance in Tiers 3 and 4 will have a per script maximum in Tiers 3 and 4. Pharmacy plans with a deductible and coinsurance for Tiers 1 and 2 will not have a per script maximum as part of the Tier 3 and 4 benefit.

Small Group ACA product details – 1 to 50 employees

The plan naming structure includes these elements:

Anthem + metal tier + [network name] + product type + copay or deductible/coinsurance/out-of-pocket maximum

The below overview represents in-network benefits. For more plan information, please refer to the Summary of Benefits (SOB). To find a specific SOB for any of these plans, visit **plan-summaries.anthem.com/sobdps/**.

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HealthKeepers POS plans

	Silver plans				Bronze plans
Plan type	POS HSA				POS
Plan name	Anthem HealthKeepers Silver OAPOS 4500/20%/7000 w/HSA	Anthem HealthKeepers Silver OAPOS 5000/20%/7000 w/HSA	Anthem HealthKeepers Silver OAPOS 6000/20%/7000 w/HSA	Anthem HealthKeepers Silver OAPOS 6850/0%/6850 w/HSA	Anthem HealthKeepers Bronze OAPOS 8500/0%/8500
Network	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers	HealthKeepers
Contract code[1]	5L5X	5L8F	5L65	5L89	5L61
Deductible[2] (individual/family)	$4,500/$9,000	$5,000/$10,000	$6,000/$12,000	$6,850/$13,700	$8,500/$17,000
Coinsurance	20%	20%	20%	0%	0%
Out-of-pocket maximum (individual/family)	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000	$6,850/$13,700	$8,500/$17,000
Office visits: EPHC[3]	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Office visits: Primary care (PCP)/ Specialist (SPC)[4]/retail health clinic (RHC)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Online doctor visits: LiveHealth Online[5]	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Urgent care (facility)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Emergency room (facility)[6]	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Independent facility: ambulatory outpatient surgery center	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Independent facility: X-ray and ultrasound	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Independent facility: advanced diagnostic imaging (MRI, CT scan, etc.)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital outpatient surgery facility	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Prescription drugs: network/drug list	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select	Standard with R90/Select
Pharmacy deductible[7] (individual/family)	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies
Retail pharmacy: 30-day supply[8] (tier 1/tier 2/tier 3/tier 4)	20%	20%	20%	0%	0%

Ω Site of Service plan may have reduced cost shares for laboratory services received at an independent lab; radiology and advanced diagnostic imaging services received at an independent radiology center; and outpatient surgery received at an ambulatory surgical center.

‡ For plans with a PreventiveRx benefit, the deductible will be waived for Tiers 1 and 2, then the applicable copay/coinsurance applies.

1 Please see benefit proposal for final contract code. Plan year (PY) and Calendar year (CY) contracts share the same contract code.

2 All plans have **embedded** deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible or OOP maximum amount paid by an individual family member applies to the family deductible/OOP maximum amount, but no individual family member pays more to the family deductible/OOP maximum than their individual deductible/OOP maximum amount.

3 Some plans include a reduced cost share when seeing an Enhanced Personal Health Care provider (EPHC).

4 Specialist (SPC) cost share applies to specialist office and LiveHealth Online (LHO) specialist visits.

5 Cost share applies to LiveHealth Online primary care medical doctor visits and behavioral health (mental health / substance abuse) visits.

6 When a member's plan requires a copay for an emergency room facility visit and the member is then directly admitted to the hospital, the initial emergency room facility visit copay will be waived if the plan includes a copay for hospital admission. If the member's cost share for hospital admission is coinsurance, then the initial emergency room facility copay will not be waived.

7 For plans with a deductible, the pharmacy cost share applies after deductible for the tiers as listed. For plans with a separate pharmacy deductible, the deductible is combined for retail and home delivery.

8 Retail pharmacy cost shares apply to a 30-day supply at a retail pharmacy. Members will pay more for up to a 90-day supply at home delivery and Rx 90 retail pharmacies. Specialty drug benefits are covered up to a 30-day supply limit. Any plan that has a pharmacy copay in Tiers 1 and 2 and a coinsurance in Tiers 3 and 4 will have a per script maximum in Tiers 3 and 4. Pharmacy plans with a deductible and coinsurance for Tiers 1 and 2 will not have a per script maximum as part of the Tier 3 and 4 benefit.

Exclusions and limitations

In this section, you'll find a review of items that are not covered by your plan. Excluded items will not be covered even if the service, supply, or equipment is medically necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as covered services. This section is not meant to be a complete list of all the items that are excluded by your plan. For more detail, please refer to the Certificate of Coverage/Evidence of Coverage ("Booklet").

We will have the right to make the final decision about whether services or supplies are medically necessary and if they will be covered by your plan.

Medical plans

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 members 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 members to give them test results.

3. **Aids for non-verbal communication** - Devices and computers to assist in communication and speech except for speech aid devices and tracheoesophageal voice devices approved by us.
4. **Alternative / complementary medicine** - Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a. Acupuncture,
   b. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   c. Holistic medicine,
   d. Homeopathic medicine,
   e. Hypnosis,
   f. Aroma therapy,
   g. Massage and massage therapy,
   h. Reiki therapy,
   i. Herbal, vitamin or dietary products or therapies,
   j. Naturopathy,
   k. Thermography,
   l. Orthomolecular therapy,
   m. Contact reflex analysis,
   n. Bioenergial synchronization technique (BEST),
   o. Iridology-study of the iris,
   p. Auditory integration therapy (AIT),
   q. Colonic irrigation,
   r. Magnetic innervation therapy,
   s. Electromagnetic therapy,
   t. Neurofeedback / biofeedback.
5. **Applied behavioral treatment** - including, but not limited to, applied behavior analysis and intensive behavior interventions for all indications except as described under Autism Services in the "What's Covered" section, unless otherwise required by law.
6. **Autopsies** - Autopsies and post-mortem testing. [***PPO only***: unless requested by us as stated in "Physical Examinations and Autopsy" in the "General Provisions" section of the Booklet.
7. **Before effective date or after termination date** - Charges for care members get before their effective date or after their coverage ends, except as written in this plan.
8. **Certain providers** - Services members get from providers that are not licensed by law to provide covered services as defined in the Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians and athletic trainers.
9. **Charges not supported by medical records** - Charges for services not described in the member's medical records.
10. **Charges over the maximum allowed amount** - Charges over the maximum allowed amount for covered services.
11. **Clinical trial non-covered services** - Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-investigational treatments.
12. **Clinically equivalent alternatives** - Certain prescription drugs may not be covered if the member could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give similar results for a disease or condition. If members have questions about whether a certain drug is covered and which drugs fall into this group, they should call the number on the back of their identification card or visit anthem.com.

    If a member or the member's doctor believes a different prescription drug should be used, please have the doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

13. **Complications of/or services related to non-covered services** - Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this plan. Directly related means that the care took place as a direct result of the non-covered service and would not have taken place without the non-covered service.
14. **Compound drugs** - Compound drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: ***Approved Drug Products with Therapeutic Equivalence Evaluations***, require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
15. [***Option to be added for those groups that qualify to opt out:*** **Contraceptives** - Contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants.]

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

    This exclusion does not apply to:

    a. Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
    b. Surgery or procedures to correct congenital abnormalities that cause functional impairment.
    c. Surgery or procedures on newborn children to correct congenital abnormalities.
17. **Court ordered testing** - Court ordered testing or care unless medically necessary.
18. **Cryopreservation** - Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage and thawing.
19. **Custodial care** - Custodial care, convalescent care or rest cures. This exclusion does not apply to hospice services.
20. **Delivery charges** - Charges for delivery of prescription drugs.
21. **Dental devices for snoring** - Oral appliances for snoring.
22. **Dental services**

    a. Dental care for members age 19 and older, unless covered by the medical benefits of this plan.
    b. Dental services or health care services not specifically listed as covered in the Booklet (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code), unless covered by the medical benefits of this plan).
    c. Services of anesthesiologists unless required by law.
    d. Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, and general anesthesia) are not covered when given separate from complex surgical services, except as required by law.
    e. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, and gnathologic recordings.
    f. Dental services provided solely for the purpose of improving the appearance of the teeth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
    g. Case presentations.
    h. Athletic mouth guards.
    i. Enamel microabrasion and odontoplasty.
    j. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the plan. The exception to this exclusion for root canal retreatment as described in "Endodontic Therapy" in the "What's Covered" section.
    k. Bacteriologic tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this plan.
    l. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    m. Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this plan.
    n. Separate services billed when they are an inherent component of another covered service.
    o. Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
    p. Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
    q. Additional, elective or enhanced prosthodontic procedures including, but not limited to, connector bar(s), stress breakers and precision attachments.
    r. Placement or removal of sedative filling, base or liner used under a restoration that is billed separately from a restoration procedure (such as filling).
    s. Pulp vitality tests.
    t. Adjunctive diagnostic tests.
    u. Incomplete root canals.
    v. Cone beam images.
    w. Anatomical crown exposure.
    x. Temporary anchorage devices.
    y. Sinus augmentation.
    z. Oral hygiene instructions.
    aa. Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials and the procedures used to prepare and place materials in the canals (tooth roots).
    ab. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    ac. For dental services received prior to the effective date of this plan or received after the coverage under this plan has ended.
    ad. Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
    ae. Implant services, including maintenance or repair to an implant or implant abutment.
    af. Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
    ag. 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.
23. **Drugs contrary to approved medical and professional standards** - Drugs given to a member or prescribed in a way that is against approved medical and professional standards of practice.
24. **Drugs over quantity or age limits** - Drugs which are over any quantity or age limits set by the plan or by us. Quantity limits do not apply to prescriptions for inhalants to treat asthma.
25. **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.
26. **Drugs prescribed by providers lacking qualifications/registrations/certifications** - Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by HealthKeepers (HMO plans) or Anthem (PPO plans).
27. **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.
28. **Educational services** - Services, supplies or room and board for teaching, vocational, or self training purposes. This includes, but is not limited to boarding

schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

29. **Emergency room services for non-emergency care** - Services provided in an emergency room that do not meet the definition of emergency. This includes but is not limited to, suture removal in an emergency room. For non-emergency care, members should use the closest in-network urgent care center or their primary care physician.
30. **Experimental or investigational services** - Services or supplies that we find are experimental / investigational. This also applies to services related to experimental / investigational services, whether a member gets them before, during, or after he or she gets the experimental / investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it a covered services if we concludee deem it is experimental / investigational.

    Please see the "Clinical Trials" section of "What's Covered" for details about coverage for services given to you as a participant in an approved clinical trial if the services are covered services under this plan. Please also read the "Experimental or Investigational" definition in the "Definitions" section at the end of the Booklet for the criteria used in deciding whether a service is experimental or investigational.
31. **Eyeglasses and contact lenses** - Eyeglasses and contact lenses to correct a member's eyesight unless otherwise indicated as covered services in the Booklet. This exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.
32. **Eye exercises** - Orthoptics and vision therapy.
33. **Eye surgery** - Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
34. **Family members** - Services prescribed, ordered, referred by or given by a member of a member's immediate family, including spouse, child, brother, sister, parent, in-law, or self.
35. **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 patients with diabetes or vascular disease.
36. **Foot orthotics** - Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
37. **Foot surgery** - Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
38. **Free care** - Services members would not have to pay for if they didn't have this plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services members get from workers' compensation, and services from free clinics.

    If your group is not required to have Workers' Compensation coverage, this exclusion does not apply. This exclusion will apply if the member gets the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation, and whether or not the member gets payments from any third party.
39. **Growth hormone treatment** - Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
40. **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.
41. **Hearing aids** - Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in the Booklet. This exclusion does not apply to cochlear implants.
42. **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. The exception to this exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.
43. **Hospital services billed separately** - Services rendered by hospital resident doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of hospitals, labs or other institutions, and charges included in other duplicate billings.
44. **Hyperhidrosis treatment** - Medical and surgical treatment of excessive sweating (hyperhidrosis).
45. **Infertility treatment** - Treatment related to infertility, except as outlined in the "Maternity and Reproductive Health" sub-section in the "What's Covered" section of the Booklet.
46. **Lost or stolen drugs** - Refills of lost or stolen drugs.
47. **Maintenance therapy** - Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps members keep their 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" as described in the "What's Covered" section of the Booklet.
48. **Medical equipment, devices and supplies**
    a. Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    b. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    c. Non-medically necessary enhancements to standard equipment and devices.
    d. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in the 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 is the member's responsibility.
    e. Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies,

dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section of the Booklet.

49. **Medicare** - For which benefits are payable under Medicare Parts A and/or B, except as required by law, as described in the section titled "Medicare" in "General Provisions."
50. **Missed or cancelled appointments** - Charges for missed or cancelled appointments.
51. **Non-approved drugs** - Drugs not approved by the FDA.
52. **Non-approved facility** - Services from a provider that does not meet the definition of facility.
53. **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.
54. **Nutritional or dietary supplements** - Nutritional and/or dietary supplements, except as described in the Booklet or that we must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that members can buy over the counter and those members can get without a written prescription or from a licensed pharmacist.
55. **Off label use** - Off label use, unless we must cover it by law or if we approve it.
56. **Oral surgery** - Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in the Booklet.
57. [*EPO Only:* **Out-of-network care** - Services from a provider that is not in our network. This does not apply to emergency care, urgent care or authorized services.]
58. **Personal care, convenience and mobile/wearable devices**
    a. Items for personal comfort, convenience, protective, 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; or
    f. Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
    g. Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
59. **Private duty nursing** - Private duty nursing services given in a hospital or skilled nursing facility. Private duty nursing services are a covered service only when given as part of the "Home Care Services" benefit.
60. **Prosthetics** - Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. The exception to this exclusion is wigs needed after cancer treatment, as described in the "Prosthetics" portion of "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" in the "What's Covered" section.
61. **Residential accommodations** - Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility, or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:
    a. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    b. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    c. Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included. Licensed professional counseling, as described in the "What's Covered" section of the Booklet, and provided as part of these programs, is considered a covered service.
62. **Routine physicals and immunizations** - Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
63. **Sanctioned or excluded providers** - Any service, drug, drug regimen, treatment, or supply, furnished, ordered, or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to emergency care.
64. [*EPO only:* **Services received outside of the United States** - Services rendered by providers located outside the United States, unless the services are for emergency care, urgent care and emergency ambulance.]
65. **Sexual dysfunction** - Services or supplies for male or female sexual problems.
66. **Stand-by charges** - Stand-by charges of a doctor or other provider.
67. **Sterilization** - Services to reverse an elective sterilization.
68. [*Option to be added for those groups that qualify to opt out:* **Sterilization** - For female sterilization or reversal of sterilization.]
69. **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).
70. **Telemedicine** - Non-interactive telemedicine services, such as audio-only telephone conversations, electronic mail message, fax transmissions or online questionnaire.
71. **Temporomandibular joint treatment** - Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
72. **Travel costs** - Mileage, lodging, meals, and other member-related travel costs except as described in this plan.
73. **Vein treatment** - Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

74. **Vision services**
    a. Eyeglass lenses, frames, or contact lenses for members age 19 and older, unless listed as covered in the Booklet.
    b. Safety glasses and accompanying frames.
    c. For two pairs of glasses in lieu of bifocals.
    d. Plano lenses (lenses that have no refractive power).
    e. Lost or broken lenses or frames unless the member has reached their normal interval for service when seeking replacements.
    f. Vision services not listed as covered in the Booklet.
    g. Cosmetic lenses or options such as special lens coatings or non-prescription lenses, unless specifically listed in the Booklet.
    h. Blended lenses.
    i. Oversize lenses.
    j. Sunglasses and accompanying frames.
    k. For services or supplies combined with any other offer, coupon or in-store advertisement or for certain brands of frames where the manufacturer does not allow discounts.
    l. For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.
    m. Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
75. **Waived cost-shares out of network** - For any service for which members are responsible under the terms of this plan to pay a copay, coinsurance or deductible, and the copay, coinsurance or deductible is waived by an out-of-network provider.
76. **Weight loss programs** - Programs, whether or not under medical supervision, unless listed as covered in the Booklet.

    This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
77. **Weight loss surgery / bariatric surgery** - This includes, but is not limited to, Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partially 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.
78. **Wilderness or other outdoor camps and/or programs** - Licensed professional counseling, as described in the "What's Covered" section of the Booklet, and provided as part of these programs, is considered a covered service.

Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above exclusions, certain items are not covered under the prescription drug retail or home delivery (mail order) pharmacy benefit:

1. **Administration charges** - Charges for the administration of any drug except for covered immunizations as approved by us or the PBM.
2. **Charges not supported by medical records** - Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in the member's medical records.
3. **Clinical trial non-covered services** - Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-investigational treatments.
4. **Compound drugs** - Compound drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, 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.
5. [*Option to exclude for groups that qualify to opt out:* **Contraceptives** - Contraceptive drugs, injectable contraceptive drugs and patches unless we must cover them by law.]
6. **Contrary to approved medical and professional standards** - Drugs given to a member or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery charges** - Charges for delivery of prescription drugs.
8. **Drugs given at the provider's office / facility** - Drugs a member takes at the time and place where the member was given them or where the prescription order is issued. This includes samples given by a doctor. This exclusion does not apply to prescription drugs used with a diagnostic service, prescription drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or prescription drugs covered under the "Medical and Surgical Supplies" benefit - they are covered services.
9. **Drugs not on the Anthem prescription drug list (a formulary)** - You can get a copy of the list by calling us or visiting anthem.com. If a member or the member's doctor believes the member needs a certain prescription drug not on the list, please refer to "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
10. **Drugs over quantity or age limits** - Drugs which are over any quantity or age limits set by the plan or us.
11. **Drugs over the quantity prescribed or refills after one year** - Prescription drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
12. **Drugs prescribed by providers lacking qualifications/registrations/certifications** - Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
13. **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.
14. **Family members** - Services prescribed, ordered, referred by or given by a member or a member's immediate family, including spouse, child, brother, sister, parent, in-law, or self.
15. **Gene therapy** - Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a

Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.

16. **Growth hormone treatment** - Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
17. **Hyperhidrosis treatment** - Prescription drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
18. **Infertility drugs** - Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
19. **Items covered as durable medical equipment (DME)** - Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices, Orthotic, Prosthetics, and Medical and Surgical Supplies" benefit. Please see that section for details.
20. **Items covered under the "Allergy Services" benefit** - Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
21. **Lost or stolen drugs** - Refills of lost or stolen drugs.
22. **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.
23. **Non-approved drugs** - Drugs not approved by the FDA.
24. **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.
25. **Nutritional or dietary supplements** - Nutritional and/or dietary supplements, except as described in the Booklet or that we must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that members can buy over the counter and those members can get without a written prescription or from a licensed pharmacist.
26. **Off label use** - Off label use, unless we must cover the use by law or if we, or the PBM, approve it. The exception to this exclusion is described in "Covered Prescription Drugs" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.
27. **Onychomycosis drugs** - Drugs for onychomycosis (toenail fungus) except when we allow it to treat members who are immuno-compromised or diabetic.
28. **Over-the-counter items** - Drugs, devices and products permitted to be dispensed without a prescription and available over the counter. This exclusion does not apply to over-the-counter products we must cover as a "Preventive Care" benefit under federal law with a prescription.
29. **Sanctioned or excluded providers** - Any drug, drug regimen, treatment, or supply that is furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
30. **Sexual dysfunction drugs** - Drugs to treat sexual or erectile problems.
31. **Syringes** - Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
32. **Weight loss drugs** - Any drug mainly used for weight loss.

HMOPOS plans – This brochure refers to AHK-VA-HMOPOS-EOC (1/21) and form numbers:

- AHK-VA-HMOPOS-SOB-TVA2fS1 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2fS4 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2fS6 (1/21)
- AHK-VA-HMOPOS-SOB-TVA1G17 (1/21)
- AHK-VA-HMOPOS-SOB-TVA1G3 (1/21)
- AHK-VA-HMOPOS-SOB-TVA1G5 (1/21)
- AHK-VA-HMOPOS-SOB-TVA1P1 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RG1 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RG11 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RG38 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RG63 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RG64 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RP1 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RP2 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RS15 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RS2 (1/21)
- AHK-VA-HMOPOS-SOB-TVA2-RS5 (1/21)
- AHK-VA-HMOPOS-SOB-TVA3B33 (1/21)
- AHK-VA-HMOPOS-SOB-TVA3G4 (1/21)
- AHK-VA-HMOPOS-SOB-TVA3G8-HSA-PrevRx (1/21)
- AHK-VA-HMOPOS-SOB-TVA3S2-HSA-rxC-PrevRx (1/21)
- AHK-VA-HMOPOS-SOB-TVA3S30-HSA-PrevRx (1/21)
- AHK-VA-HMOPOS-SOB-TVA3S32-HSA-PrevRx (1/21)
- AHK-VA-HMOPOS-SOB-TVA3S33-HSA-PrevRx (1/21)
- AHK-VA-HMOPOS-SOB-TVA3S4-HSA-PrevRx (1/21)
- AHK-VA-HMOPOS-SOB-TVA3S5-HSA-PrevRx (1/21)

PPO and EPO plans – This brochure refers to ABCBS-VA-PPO-COC (1/21) and form numbers:

- ABCBS-VA-PPO-SOB-TVA1G17 (1/21)
- ABCBS-VA-PPO-SOB-TVA1G3 (1/21)
- ABCBS-VA-PPO-SOB-TVA1G5 (1/21)
- ABCBS-VA-PPO-SOB-TVA1P1 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RG1 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RG11 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RG38 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RG63 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RG64 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RP1 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RP2 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RS15 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RS2 (1/21)
- ABCBS-VA-PPO-SOB-TVA2-RS5 (1/21)
- ABCBS-VA-PPO-SOB-TVA3B33 (1/21)
- ABCBS-VA-PPO-SOB-TVA3G4 (1/21)
- ABCBS-VA-PPO-SOB-TVA3G8-HSA-PrevRx (1/21)
- ABCBS-VA-PPO-SOB-TVA3S2-HSA-rxC-PrevRx (1/21)
- ABCBS-VA-PPO-SOB-TVA3S30-HSA-PrevRx (1/21)
- ABCBS-VA-PPO-SOB-TVA3S32-HSA-PrevRx (1/21)
- ABCBS-VA-PPO-SOB-TVA3S33-HSA-PrevRx (1/21)
- ABCBS-VA-PPO-SOB-TVA3S4-HSA-PrevRx (1/21)
- ABCBS-VA-PPO-SOB-TVA3S5-HSA-PrevRx (1/21)
- ABCBS-VA-EPO-SOB-TVA-2KG1 (1/21)
- ABCBS-VA-EPO-SOB-TVA-2KG2 (1/21)
- ABCBS-VA-EPO-SOB-TVA-2KG3 (1/21)
- ABCBS-VA-EPO-SOB-TVA-2KP1 (1/21)
- ABCBS-VA-EPO-SOB-TVA-2KS1 (1/21)

We're in this together

Let us help you save more time

Thank you for letting us partner with you. We understand that providing health benefits is an important decision for small businesses. That's why we're doing everything we can to offer the highest-quality coverage while keeping costs down. And we're right by your side to help make things simpler for you through the process.

Easier than ever

Our plans were put together with small businesses in mind – they're simple to understand, administer and use!

Questions? We're here to help. Call your Anthem representative.

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