Georgia

Effective January 1, 2020

Small Group ACA medical products

Anthem REST EASY | SMALL BUSINESS

101152GAEENABS 7/19

Small Group product details – 2* to 50 employees

The plan naming structure includes these elements:

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

The below overview represents 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.

	Bronze plans						
Plan type	POS					POS HSA	
Plan name	Anthem Bronze Blue Open Access POS 4000/10%/8150 Plus†	Anthem Bronze Blue Open Access POS 5000/0%/8150†	Anthem Bronze Blue Open Access POS 6000/10%/8150 Plus†	Anthem Bronze Blue Open Access POS 6000/30%/8150†	Anthem Bronze Blue Open Access POS 8000/40%/8150†	Anthem Bronze Pathway Enhanced POS 5500/40%/6850 w/HSA Focus†	Anthem Bronze Pathway Enhanced POS 6000/20%/6850 w/HSA Focus†
Network	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Pathway Enhanced	Pathway Enhanced
Contract code	4AF8	4AG6	4AF4	4AEQ	4AGL	4AEN	4AFJ
Deductible[1] (individual/family)	$4,000/$8,000	$5,000/$10,000	$6,000/$12,000	$6,000/$12,000	$8,000/$16,000	$5,500/$11,000	$6,000/$12,000
Coinsurance	10%	0%	10%	30%	40%	40%	20%
Out-of-pocket maximum (individual/family)	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$6,850/$13,700	$6,850/$13,700
Office visits: Primary care (PCP)/ Specialist (SPC)/retail health clinic (RHC)	$35 for first 3 visits, then deductible and 10% coinsurance	PCP: $45 SPC: $90 RHC: $45	$35 for first 3 visits, then deductible and 10% coinsurance	$35 for first 3 visits, then deductible and 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance
Online doctor visits: Preferred[2]	$0 for first 12 visits, then $25	$0 for first 12 visits, then $35	$0 for first 12 visits, then $25	$0 for first 12 visits, then $25	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance
Urgent care (facility)[3]	Deductible, then 10% coinsurance	$100	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance
Emergency room (facility)[3]	Deductible, then $500	$600, then deductible, then 0% coinsurance	Deductible, then $300	Deductible, then $300	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance
Outpatient surgery (facility)	$1,500	$600, then deductible, then 0% coinsurance	$3,000	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance
Hospital inpatient admission	Deductible, then 10% coinsurance	$1,250, then deductible, then 0% coinsurance per admission	Deductible, then 10% coinsurance	Deductible, then $500 per admission	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance
Prescription drugs: network/drug list[4]	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[5] (individual/family)	Tier 1: No deductible Tiers 2-4: $500/$1,000 Pharmacy deductible	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $500/$1,000 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‡
Retail pharmacy: 30-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: 40% Level 2: 50%	Level 1: 40% Level 2: 50%	Level 1: 20% Level 2: 30%
Home delivery pharmacy: 90-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	40%	40%	20%

*Groups of one are eligible for Small Group plans under certain conditions.

† Plan has Home Delivery Choice.

‡ Deductible waived for drugs on the HSA PreventiveRx Plus drug list.

1 All plans have embedded deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible amount contributed by an individual family member applies to the family deductible amount, but no individual family member contributes more to the family deductible than their individual deductible amount.

2 When using LiveHealth Online, members can have face-to-face video visits with board-certified doctors right from their computer or mobile device.

3 Additional services received in an urgent care and emergency room setting are subject to deductible and applicable coinsurance.

4 All pharmacy plans use the Rx Choice Tiered network with R90 and the Select drug list. To see if a pharmacy is in Level 1 or Level 2, go to anthem.com/findadoctor. Members save money by choosing a Level 1 pharmacy. Drugs not on the Select drug list are not covered.

5 For plans with a deductible, the cost share applies after deductible for the tiers listed. For plans with a separate pharmacy deductible, the deductible is combined for retail (Level 1 and Level 2) and home delivery.

6 Pharmacy plans use a 4-tier (tier 1a/tier 1b/tier 2/tier 3/tier 4) drug list. For plan details, please refer to the Summary of Benefits (SOB) available at **plan-summaries.anthem.com/sobdps/**.

2

Small Group product details – 2* to 50 employees

The plan naming structure includes these elements:

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

The below overview represents 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.

	Bronze plans	Silver plans					
Plan type	POS HSA	POS					
Plan name	Anthem Bronze Blue Open Access POS 6100/10%/6850 w/HSA†	Anthem Silver Blue Open Access POS 2000/0%/8150†	Anthem Silver Blue Open Access POS 2000/35%/8150 Plus†	Anthem Silver Blue Open Access POS 2500/20%/8150†	Anthem Silver Blue Open Access POS 2500/30%/8150 Plus†	Anthem Silver Blue Open Access POS 3000/0%/8150†	Anthem Silver Blue Open Access POS 3000/20%/8150†
Network	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS
Contract code	4AEL	4AG4	4AFA	4AES	4AFC	4AGA	4AFY
Deductible[1] (individual/family)	$6,100/$12,200	$2,000/$6,000	$2,000/$6,000	$2,500/$7,500	$2,500/$7,500	$3,000/$6,000	$3,000/$6,000
Coinsurance	10%	0%	35%	20%	30%	0%	20%
Out-of-pocket maximum (individual/family)	$6,850/$13,700	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300
Office visits: Primary care (PCP)/ Specialist (SPC)/retail health clinic (RHC)	PCP: Deductible, then $45 SPC: Deductible, then $90 RHC: Deductible, then $45	PCP: $45 SPC: $90 RHC: $45	$35 for first 3 visits, then deductible and 35% coinsurance	PCP: $45 SPC: $90 RHC: $45	$35 for first 3 visits, then deductible and 30% coinsurance	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45
Online doctor visits: Preferred[2]	Deductible, then $35	$0 for first 12 visits, then $35	$0 for first 12 visits, then $25	$0 for first 12 visits, then $35	$0 for first 12 visits, then $25	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35
Urgent care (facility)[3]	Deductible, then $100	$100	Deductible, then 35% coinsurance	$100	Deductible, then 30% coinsurance	$100	$100
Emergency room (facility)[3]	Deductible, then $500	$500, then deductible, then 0% coinsurance	Deductible, then $300	Deductible, then $400	Deductible, then $300	$500, then deductible, then 0% coinsurance	Deductible, then $400
Outpatient surgery (facility)	Deductible, then 10% coinsurance	$500, then deductible, then 0% coinsurance	$1,500	Deductible, then 20% coinsurance	$2,400	$500, then deductible, then 0% coinsurance	Deductible, then 20% coinsurance
Hospital inpatient admission	Deductible, then 10% coinsurance	$1,000, then deductible, then 0% coinsurance per admission	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	$1,000, then deductible, then 0% coinsurance per admission	Deductible, then 20% coinsurance
Prescription drugs: network/drug list[4]	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[5] (individual/family)	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: No deductible	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	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $500/$1,000 Pharmacy deductible
Retail pharmacy: 30-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%
Home delivery pharmacy: 90-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%

*Groups of one are eligible for Small Group plans under certain conditions.

† Plan has Home Delivery Choice.

‡ Deductible waived for drugs on the HSA PreventiveRx Plus drug list.

1 All plans have embedded deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible amount contributed by an individual family member applies to the family deductible amount, but no individual family member contributes more to the family deductible than their individual deductible amount.

2 When using LiveHealth Online, members can have face-to-face video visits with board-certified doctors right from their computer or mobile device.

3 Additional services received in an urgent care and emergency room setting are subject to deductible and applicable coinsurance.

4 All pharmacy plans use the Rx Choice Tiered network with R90 and the Select drug list. To see if a pharmacy is in Level 1 or Level 2, go to anthem.com/findadoctor. Members save money by choosing a Level 1 pharmacy. Drugs not on the Select drug list are not covered.

5 For plans with a deductible, the cost share applies after deductible for the tiers listed. For plans with a separate pharmacy deductible, the deductible is combined for retail (Level 1 and Level 2) and home delivery.

6 Pharmacy plans use a 4-tier (tier 1a/tier 1b/tier 2/tier 3/tier 4) drug list. For plan details, please refer to the Summary of Benefits (SOB) available at **plan-summaries.anthem.com/sobdps/**.

3

Small Group product details – 2* to 50 employees

The plan naming structure includes these elements:

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

The below overview represents 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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	Silver plans						
Plan type	POS						
Plan name	Anthem Silver Blue Open Access POS 3500/30%/8150†	Anthem Silver Blue Open Access POS 4000/0%/8150†	Anthem Silver Blue Open Access POS 4000/20%/8150†	Anthem Silver Pathway Enhanced POS 4750/0%/8150 Focus†	Anthem Silver Blue Open Access POS 5000/20%/8150†	Anthem Silver Blue Open Access POS 5000/30%/8150†	Anthem Silver Blue Open Access POS 5500/0%/8150†
Network	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Pathway Enhanced	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS
Contract code	4AEE	4AGC	4AFW	4AFE	4AEC	4AGO	4AEJ
Deductible[1] (individual/family)	$3,500/$7,000	$4,000/$8,000	$4,000/$8,000	$4,750/$9,500	$5,000/$10,000	$5,000/$10,000	$5,500/$11,000
Coinsurance	30%	0%	20%	0%	20%	30%	0%
Out-of-pocket maximum (individual/family)	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300	$8,150/$16,300
Office visits: Primary care (PCP)/ Specialist (SPC)/retail health clinic (RHC)	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45
Online doctor visits: Preferred[2]	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35
Urgent care (facility)[3]	$100	$100	$100	$100	$100	$100	$100
Emergency room (facility)[3]	Deductible, then $400	$500, then deductible, then 0% coinsurance	Deductible, then $400	Deductible, then $400	Deductible, then $400	Deductible, then $400	Deductible, then $400
Outpatient surgery (facility)	Deductible, then 30% coinsurance	$500, then deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 30% coinsurance	$1,000, then deductible, then 0% coinsurance per admission	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Prescription drugs: network/drug list[4]	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[5] (individual/family)	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-4: No deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible	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: $750/$1,500 Pharmacy deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%
Home delivery pharmacy: 90-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%

*Groups of one are eligible for Small Group plans under certain conditions.

† Plan has Home Delivery Choice.

‡ Deductible waived for drugs on the HSA PreventiveRx Plus drug list.

1 All plans have embedded deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible amount contributed by an individual family member applies to the family deductible amount, but no individual family member contributes more to the family deductible than their individual deductible amount.

2 When using LiveHealth Online, members can have face-to-face video visits with board-certified doctors right from their computer or mobile device.

3 Additional services received in an urgent care and emergency room setting are subject to deductible and applicable coinsurance.

4 All pharmacy plans use the Rx Choice Tiered network with R90 and the Select drug list. To see if a pharmacy is in Level 1 or Level 2, go to anthem.com/findadoctor. Members save money by choosing a Level 1 pharmacy. Drugs not on the Select drug list are not covered.

5 For plans with a deductible, the cost share applies after deductible for the tiers listed. For plans with a separate pharmacy deductible, the deductible is combined for retail (Level 1 and Level 2) and home delivery.

6 Pharmacy plans use a 4-tier (tier 1a/tier 1b/tier 2/tier 3/tier 4) drug list. For plan details, please refer to the Summary of Benefits (SOB) available at **plan-summaries.anthem.com/sobdps/**.

4

Small Group product details – 2* to 50 employees

The plan naming structure includes these elements:

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

The below overview represents 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.

	Silver plans					Gold plans	
Plan type	POS		POS HSA			POS	
Plan name	Anthem Silver Pathway Enhanced POS 6000/20%/8150 Focus†	Anthem Silver Blue Open Access POS 6350/0%/8150†	Anthem Silver Blue Open Access POS 2800/20%/6850 w/HSA†	Anthem Silver Blue Open Access POS 5500/0%/6850 w/HSA†	Anthem Silver Blue Open Access POS 6500/0%/6850 w/HSA†	Anthem Gold Blue Open Access POS 0%/6000 CP†	Anthem Gold Blue Open Access POS 0%/8150 CP†
Network	Pathway Enhanced	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS
Contract code	4AEG	4AFG	4AG2	4AF0	4AF2	4AEA	4AE8
Deductible[1] (individual/family)	$6,000/$12,000	$6,350/$12,700	$2,800/$8,400	$5,500/$11,000	$6,500/$13,000	$0/$0	$0/$0
Coinsurance	20%	0%	20%	0%	0%	0%	0%
Out-of-pocket maximum (individual/family)	$8,150/$16,300	$8,150/$16,300	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$6,000/$12,000	$8,150/$16,300
Office visits: Primary care (PCP)/ Specialist (SPC)/retail health clinic (RHC)	PCP: $45 SPC: $90 RHC: $45	PCP: $45 SPC: $90 RHC: $45	PCP: Deductible, then $45 SPC: Deductible, then $90 RHC: Deductible, then $45	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	PCP: $30 SPC: $60 RHC: $30	PCP: $30 SPC: $60 RHC: $30
Online doctor visits: Preferred[2]	$0 for first 12 visits, then $35	$0 for first 12 visits, then $35	Deductible, then $35	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	$0 for first 12 visits, then $20	$0 for first 12 visits, then $20
Urgent care (facility)[3]	$100	$100	Deductible, then $100	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	$100	$100
Emergency room (facility)[3]	Deductible, then $400	Deductible, then $400	Deductible, then $300	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	$300	$600
Outpatient surgery (facility)	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	$400	$2,000
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	$750 copay per day up to 4 days per admission	$2,000 copay per day up to 4 days per admission
Prescription drugs: network/drug list[4]	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[5] (individual/family)	Tiers 1-2: No deductible Tiers 3-4: Medical deductible applies	Tiers 1-4: No deductible	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: Medical deductible applies‡	Tiers 1-4: No deductible	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: 0% Level 2: 10%	Level 1: 0% Level 2: 10%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%
Home delivery pharmacy: 90-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	0%	0%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%

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† Plan has Home Delivery Choice.

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6 Pharmacy plans use a 4-tier (tier 1a/tier 1b/tier 2/tier 3/tier 4) drug list. For plan details, please refer to the Summary of Benefits (SOB) available at **plan-summaries.anthem.com/sobdps/**.

5

Small Group product details – 2* to 50 employees

The plan naming structure includes these elements:

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

The below overview represents 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.

	Gold plans						
Plan type	POS						
Plan name	Anthem Gold Blue Open Access POS 750/20%/8150†	Anthem Gold Blue Open Access POS 1000/0%/6000†	Anthem Gold Blue Open Access POS 1000/20%/6000†	Anthem Gold Blue Open Access POS 1000/20%/6000 Plus†	Anthem Gold Blue Open Access POS 1500/10%/6000†	Anthem Gold Blue Open Access POS 1500/20%/8150†	Anthem Gold Blue Open Access POS 2000/10%/6000†
Network	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS
Contract code	4AEW	4AG8	4AFU	4AF6	4AFN	4AFQ	4AFL
Deductible[1] (individual/family)	$750/$2,250	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$1,500/$4,500	$1,500/$4,500	$2,000/$6,000
Coinsurance	20%	0%	20%	20%	10%	20%	10%
Out-of-pocket maximum (individual/family)	$8,150/$16,300	$6,000/$12,000	$6,000/$12,000	$6,000/$12,000	$6,000/$12,000	$8,150/$16,300	$6,000/$12,000
Office visits: Primary care (PCP)/ Specialist (SPC)/retail health clinic (RHC)	PCP: $30 SPC: $60 RHC: $30	PCP: $30 SPC: $60 RHC: $30	PCP: $30 SPC: $60 RHC: $30	$35 for first 3 visits, then deductible and 20% coinsurance	PCP: $30 SPC: $60 RHC: $30	PCP: $30 SPC: $60 RHC: $30	PCP: $30 SPC: $60 RHC: $30
Online doctor visits: Preferred[2]	$0 for first 12 visits, then $20	$0 for first 12 visits, then $20	$0 for first 12 visits, then $20	$0 for first 12 visits, then $25	$0 for first 12 visits, then $20	$0 for first 12 visits, then $20	$0 for first 12 visits, then $20
Urgent care (facility)[3]	$100	$100	$100	Deductible, then 20% coinsurance	$100	$100	$100
Emergency room (facility)[3]	Deductible, then $300	$400, then deductible, then 0% coinsurance	Deductible, then $300	Deductible, then $300	Deductible, then $300	Deductible, then $300	Deductible, then $300
Outpatient surgery (facility)	Deductible, then 20% coinsurance	$400, then deductible, then 0% coinsurance	Deductible, then 20% coinsurance	$1,500	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	$1,000, then deductible, then 0% coinsurance per admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance
Prescription drugs: network/drug list[4]	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[5] (individual/family)	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy 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[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%
Home delivery pharmacy: 90-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%

*Groups of one are eligible for Small Group plans under certain conditions.

† Plan has Home Delivery Choice.

‡ Deductible waived for drugs on the HSA PreventiveRx Plus drug list.

1 All plans have embedded deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible amount contributed by an individual family member applies to the family deductible amount, but no individual family member contributes more to the family deductible than their individual deductible amount.

2 When using LiveHealth Online, members can have face-to-face video visits with board-certified doctors right from their computer or mobile device.

3 Additional services received in an urgent care and emergency room setting are subject to deductible and applicable coinsurance.

4 All pharmacy plans use the Rx Choice Tiered network with R90 and the Select drug list. To see if a pharmacy is in Level 1 or Level 2, go to anthem.com/findadoctor. Members save money by choosing a Level 1 pharmacy. Drugs not on the Select drug list are not covered.

5 For plans with a deductible, the cost share applies after deductible for the tiers listed. For plans with a separate pharmacy deductible, the deductible is combined for retail (Level 1 and Level 2) and home delivery.

6 Pharmacy plans use a 4-tier (tier 1a/tier 1b/tier 2/tier 3/tier 4) drug list. For plan details, please refer to the Summary of Benefits (SOB) available at **plan-summaries.anthem.com/sobdps/**.

6

Small Group product details – 2* to 50 employees

The plan naming structure includes these elements:

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

The below overview represents 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.

	Gold plans			
Plan type	POS			POS HSA
Plan name	Anthem Gold Blue Open Access POS 2500/10%/6000†	Anthem Gold Blue Open Access POS 2500/20%/6000†	Anthem Gold Blue Open Access POS 3500/0%/6000†	Anthem Gold Blue Open Access POS 4000/0%/6850 w/HSA†
Network	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS	Blue Open Access POS
Contract code	4AFS	4AEY	4AEU	4AGE
Deductible[1] (individual/family)	$2,500/$7,500	$2,500/$7,500	$3,500/$7,000	$4,000/$8,000
Coinsurance	10%	20%	0%	0%
Out-of-pocket maximum (individual/family)	$6,000/$12,000	$6,000/$12,000	$6,000/$12,000	$6,850/$13,700
Office visits: Primary care (PCP)/ Specialist (SPC)/retail health clinic (RHC)	PCP: $30 SPC: $60 RHC: $30	PCP: $30 SPC: $60 RHC: $30	PCP: $30 SPC: $60 RHC: $30	Deductible, then 0% coinsurance
Online doctor visits: Preferred[2]	$0 for first 12 visits, then $20	$0 for first 12 visits, then $20	$0 for first 12 visits, then $20	Deductible, then 0% coinsurance
Urgent care (facility)[3]	$100	$100	$100	Deductible, then 0% coinsurance
Emergency room (facility)[3]	Deductible, then $300	Deductible, then $300	Deductible, then $300	Deductible, then 0% coinsurance
Outpatient surgery (facility)	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Prescription drugs: network/drug list[4]	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select	Rx Choice Tiered Network with R90/ Select
Pharmacy deductible[5] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: Medical deductible applies‡
Retail pharmacy: 30-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: $5/$20/$50/$90/20% Level 2: $15/$30/$60/$100/20%	Level 1: 0% Level 2: 10%
Home delivery pharmacy: 90-day supply[6] (tier 1a/tier 1b/tier 2/tier 3/tier 4)	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	$13/$50/$150/$270/20%	0%

*Groups of one are eligible for Small Group plans under certain conditions.

† Plan has Home Delivery Choice.

‡ Deductible waived for drugs on the HSA PreventiveRx Plus drug list.

1 All plans have embedded deductibles, which means each family member has an individual deductible and OOP maximum. Any deductible amount contributed by an individual family member applies to the family deductible amount, but no individual family member contributes more to the family deductible than their individual deductible amount.

2 When using LiveHealth Online, members can have face-to-face video visits with board-certified doctors right from their computer or mobile device.

3 Additional services received in an urgent care and emergency room setting are subject to deductible and applicable coinsurance.

4 All pharmacy plans use the Rx Choice Tiered network with R90 and the Select drug list. To see if a pharmacy is in Level 1 or Level 2, go to anthem.com/findadoctor. Members save money by choosing a Level 1 pharmacy. Drugs not on the Select drug list are not covered.

5 For plans with a deductible, the cost share applies after deductible for the tiers listed. For plans with a separate pharmacy deductible, the deductible is combined for retail (Level 1 and Level 2) and home delivery.

6 Pharmacy plans use a 4-tier (tier 1a/tier 1b/tier 2/tier 3/tier 4) drug list. For plan details, please refer to the Summary of Benefits (SOB) available at **plan-summaries.anthem.com/sobdps/**.

7

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.

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. **Abortion services –** Supplies, prescription drugs, and other care provided for elective (voluntary abortions and/or fetal reduction surgery.
   This exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother, as a result of incest or rape, or as recommended by a doctor.
2. **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. This exclusion does not apply to acts of terrorism.
3. **Administrative charges**
   a. Charges for the completion of 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.
4. **Aids for non-verbal communication** - Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
5. **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.
6. **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 of the Booklet unless otherwise required by law.
7. **Autopsies** - Autopsies and post-mortem testing.
8. **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.
9. **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.
10. **Charges over the maximum allowed amount** - Charges over the maximum allowed amount for covered services.
11. **Charges not supported by medical records** - Charges for services not described in the member's medical records.
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. **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.
14. **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. This exclusion does not apply to problems resulting from pregnancy.
15. **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.

16. **Contraceptives** - Non-prescription contraceptive devices unless required by law.
17. **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 reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or surgery to restore function of any body area that has been altered by illness or trauma.
18. **Court ordered testing** - Court ordered testing or care unless medically necessary.
19. **Crime** - Treatment of injury or illness that results from a crime the member committed, or tried to commit. This exclusion does not apply if the member's involvement in the crime was solely the result of a medical or mental condition, or where the member was the victim of a crime, including domestic violence.
20. **Cryopreservation** - Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
21. **Custodial care** - Custodial care, convalescent care or rest cures. This exclusion does not apply to hospice services.
22. **Delivery charges** - Charges for delivery of prescription drugs.
23. **Dental devices for snoring** - Oral appliances for snoring.
24. **Dental services**
    a. Dental care for members age 19 and older.
    b. 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.
    c. Dental services or health care services not specifically covered under the plan (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
    d. For dental services received prior to the effective date of this plan or received after the coverage under this plan has ended.
    e. Services of anesthesiologists unless required by law.
    f. Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
    g. Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
    h. 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, periodontal splinting and gnathologic recordings.
    i. Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
    j. Case presentations, office visits, consultations.
    k. Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
    l. Enamel microabrasion and odontoplasty.
    m. Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the policy/plan.
    n. Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this plan.
    o. Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this plan.
    p. Separate services billed when they are an inherent component of another covered service.
    q. Dental services for which members would have no legal obligation to pay in the absence of this or like coverage.
    r. Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
    s. Additional, elective or enhanced prosthodontic procedures including, but not limited to, connector bar(s), stress breakers and precision attachments.
    t. Provisional splinting, temporary procedures or interim stabilization.
    u. Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure (such as filling).
    v. Pulp vitality tests.
    w. Adjunctive diagnostic tests.
    x. Incomplete root canals.
    y. Cone beam images.
    z. Anatomical crown exposure.
    aa. Temporary anchorage devices.
    ab. Sinus augmentation.
    ac. Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this plan.
    ad. Oral hygiene instructions.
    ae. Occlusal or athletic mouth guards.
    af. Repair or replacement of lost/broken appliances.
    ag. Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
    ah. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    ai. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration
25. **Dental treatment** - 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 (unless listed as a covered service in the Booklet).
c. Services to help dental clinical outcomes.
d. Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

This exclusion does not apply to services that we must cover by law.

26. **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.
27. **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.
28. **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.
29. **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.
30. **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.
31. **Emergency room services for non-emergency care** - Services provided in an emergency room for conditions 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 network urgent care center or their primary care physician.
32. **Experimental or investigational services** - Services or supplies that are found to be 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 for a condition will not make it eligible for coverage if we deem it to be experimental / investigational.
33. **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.
34. **Eye exercises** - Orthoptics and vision therapy.
35. **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.
36. **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.
37. **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.
38. **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.
39. **Foot surgery** - Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
40. **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 workers' compensation benefits are not available to the member, 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.
41. **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.
42. **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.
43. **Hearing aids** - Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, for members over 18 years of age, unless listed as covered in the Booklet. This exclusion does not apply to cochlear implants.
44. **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. Private duty nursing.
    c. Food, housing, homemaker services and home delivered meals.
45. **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.
46. **Hyperhidrosis treatment** - Medical and surgical treatment of excessive sweating (hyperhidrosis).
47. **Infertility treatment** - Testing or treatment related to infertility except for diagnostic services and procedures to correct an underlying medical condition. Infertility procedures not specified in the Booklet. Reversals of elective sterilizations are not covered.
48. **Lost or stolen drugs** - Refills of lost or stolen drugs.
49. **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.

50. **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.
51. **Medicare** - Services for which benefits are payable under Medicare Parts A and/or B or would have been payable if the member had applied for Parts A and/or B, except, as listed in the Booklet or as required by federal law, as described in the section titled "Medicare" in the "General Provisions" section. If a member does not enroll in Medicare Part B, when eligible, we will calculate benefits as if he or she had enrolled. Members should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
52. **Missed or cancelled appointments** - Charges for missed or cancelled appointments.
53. **Non-approved drugs** - Drugs not approved by the FDA.
54. **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.
55. **Nutritional or dietary supplements** - Nutritional and/or dietary supplements, except as described in the Booklet or that must be covered 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.
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. **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.
58. **Private duty nursing** - Private duty nursing services.
59. **Prosthetics** - Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics except when necessitated by disease.
60. **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 is psychotherapy is included.
61. **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.
62. **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.
63. **Services received outside of the United States** - Services rendered by providers located outside of the United States, unless the services are for emergency care and emergency ambulance.
64. **Sexual dysfunction** - Services or supplies for male or female sexual problems (except male organic erectile dysfunction).
65. **Stand-by charges** - Stand-by charges of a doctor or other provider.
66. **Sterilization** - Services to reverse an elective sterilization.
67. **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).
68. **Temporomandibular joint treatment** - Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
69. **Travel costs** - Mileage, lodging, meals, and other member-related travel costs except as described in this plan.

70. **Vein treatment** - Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
71. **Vision services** - Vision care services do not include services incurred for or in connection with any of the items below:
    a. Eyeglass lenses, frames, or contact lenses for members age 19 and older, unless listed as covered in the Booklet.
    b. For safety glasses and accompanying frames.
    c. For two pairs of glasses in lieu of bifocals.
    d. For 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 or supplies not specifically listed as covered in the Booklet.
    g. Cosmetic lenses or options such as special lens coatings or non-prescription lenses, unless specifically stated as covered 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 members through age 18, no benefits are available for frames or contact lenses purchased outside of our formulary.
    m. Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
72. **Waived cost-shares out of the 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 non-network provider.
73. **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.
74. **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.
75. **Wilderness or other outdoor camps and/or programs.**

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. **Clinically-equivalent alternatives** - Certain prescription drugs may not be covered if a member could use a clinically equivalent prescription drug, unless required by law. "Clinically Equivalent" means prescription drugs that for most members, will give similar results for a disease or condition. If members have questions about whether a certain prescription drug is covered and which prescription 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 prescription drug. We will review benefits for the prescription drug from time to time to make sure the prescription drug is still medically necessary.
4. **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.
5. **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.
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. Quantity limits do not apply to prescriptions for inhalants to treat asthma.
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.
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" 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 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, 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-formulary drugs** - Non-formulary drugs except as described in this "Prescription Drugs Benefit at a Home Delivery (Mail Order) Pharmacy" section.
25. **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.
26. **Nutritional or dietary supplements** - Nutritional and/or dietary supplements, except as described in the Booklet or that must be covered 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.
27. **Onychomycosis drugs** - Drugs for onychomycosis (toenail fungus) except when we allow it to treat members who are immunocompromised or diabetic.
28. **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 may not be covered even written as a prescription. 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 must be covered 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 (except male organic erectile dysfunction)
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.

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