Ohio

Effective January 1, 2020

Small Group ACA medical product guide

Anthem REST EASY | SMALL BUSINESS

1011520HEENABS 7/19

Small Group ACA product details – 2* 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 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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	Platinum plans				Gold plans		
Plan type	PPO		HMO		PPO		
Plan name	Anthem Platinum Blue Access PPO 250/10%/2500	Anthem Platinum Blue Access PPO 500/10%/3000	Anthem Platinum Pathway Group HMO 250/10%/2500	Anthem Platinum Pathway Group HMO 500/10%/3000	Anthem Gold Blue Access PPO 500/20%/7000 Focus†	Anthem Gold Blue Access PPO 500/25%/7000	Anthem Gold Blue Access PPO 1000/20%/6400 Focus†
Network	Blue Access	Blue Access	Pathway Group HMO	Pathway Group HMO	Blue Access	Blue Access	Blue Access
Deductible[1] (individual/family)	$250/$750	$500/$1,500	$250/$750	$500/$1,500	$500/$1,500	$500/$1,500	$1,000/$3,000
Non-network deductible (individual/family)	$2,000/$6,000	$2,000/$6,000	Not applicable	Not applicable	$2,000/$4,000	$2,000/$6,000	$3,000/$6,000
Coinsurance	10%	10%	10%	10%	20%	25%	20%
Non-network coinsurance	40%	40%	Not applicable	Not applicable	50%	50%	50%
Out-of-pocket maximum[1] (individual/family)	$2,500/$5,000	$3,000/$6,000	$2,500/$5,000	$3,000/$6,000	$7,000/$14,000	$7,000/$14,000	$6,400/$12,800
Non-network out-of-pocket maximum (individual/family)	$7,500/$15,000	$9,000/$18,000	Not applicable	Not applicable	$21,000/$42,000	$21,000/$42,000	$19,200/$38,400
Office visits: Primary care (PCP)/Specialist (SPC)	PCP: $20 SPC: $40	PCP: $25 SPC: $50	PCP: $20 SPC: $40	PCP: $25 SPC: $50	PCP (children up to age 19): $0 PCP (ages 19+): $20 SPC: $50	PCP: $25 SPC: $60	PCP (children up to age 19): $0 PCP (ages 19+): $20 SPC: $50
Online doctor visits: Preferred	$10	$10	$10	$10	$5	$10	$5
Urgent care (facility)[2]	$100	$100	$100	$100	$100	$100	$100
Emergency room (facility)[2]	Deductible, then $300	Deductible, then $300	Deductible, then $300	Deductible, then $300	$250, then deductible, then 20% coinsurance	Deductible, then $400	$250, then deductible, then 20% coinsurance
Outpatient surgery (facility)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	$250, then deductible, then 20% coinsurance	Deductible, then 25% coinsurance	$250, then deductible, then 20% coinsurance
Hospital inpatient admission	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	$250, then deductible, then 20% coinsurance per admission	Deductible, then 25% coinsurance	$250, then deductible, then 20% coinsurance per admission
Prescription drugs: network/drug list	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[3] (individual/family)	Tiers 1-4: No deductible	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: No deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible
Retail pharmacy: 30-day supply[4]	Level 1: $10/$40/$75/30% up to $400 per script Level 2: $20/$50/$85/30% up to $500 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $10/$40/$75/30% up to $400 per script Level 2: $20/$50/$85/30% up to $500 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script
Home delivery pharmacy: 90-day supply	$25/$120/$225/30% up to $400 per script	$38/$150/$270/30% up to $450 per script	$25/$120/$225/30% up to $400 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script
Incentive package	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational

* Groups of one are eligible for Small Group plans under certain conditions. For more information, please contact your Anthem representative.

Δ Nonembedded deductible and out-of-pocket maximum plan; all other plans have embedded deductibles and out-of-pocket maximums.

† Focus plans have no PCP office visit copay for children under age 19.

1 Here's an overview of nonembedded versus embedded accumulator plans: A nonembedded plan means all family members share a deductible and out-of-pocket (OOP) maximum, regardless of the number of family members. The entire deductible must be met before any one family member receives benefits, and the entire OOP must be met before the family has satisfied the OOP maximum. An embedded plan 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. Similarly, any cost-sharing contributed by an individual family member applies to the family OOP maximum, but no individual family member contributes more to the family OOP maximum than their individual OOP maximum amount.

2 Some services received in an urgent care and emergency room setting are subject to deductible and applicable copay/coinsurance.

3 For plans where the medical deductible applies to covered prescription drugs, the network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, the non-network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at non-network pharmacies (retail only). For plans with a separate pharmacy deductible, this deductible applies to covered prescription drugs (in the tiers noted) obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, it also applies to covered prescription drugs obtained at non-network pharmacies (retail only).

4 Retail 90 (R90) is included on all plans. Employees can get a 90-day supply of maintenance medications from a participating retail pharmacy.

Small Group ACA product details – 2* 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 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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	Gold plans						
Plan type	PPO					PPO HSA	HMO
Plan name	Anthem Gold Blue Access PPO 1000/20%/7000	Anthem Gold Blue Access PPO 1500/20%/7000	Anthem Gold Blue Access PPO 2000/20%/7000	Anthem Gold Blue Access PPO 2500/0%/7500	Anthem Gold Blue Access PPO 3000/10%/6000	Anthem Gold Blue Access PPO 1500C/0%/3500 w/ HSA[Δ]	Anthem Gold Pathway Group HMO 500/25%/7000
Network	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Pathway Group HMO
Deductible[1] (individual/family)	$1,000/$3,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000	$3,000/$6,000	$1,500/$3,000	$500/$1,500
Non-network deductible (individual/family)	$3,000/$9,000	$4,500/$9,000	$6,000/$12,000	$7,500/$15,000	$9,000/$18,000	$4,500/$9,000	Not applicable
Coinsurance	20%	20%	20%	0%	10%	0%	25%
Non-network coinsurance	50%	50%	50%	30%	40%	30%	Not applicable
Out-of-pocket maximum[1] (individual/family)	$7,000/$14,000	$7,000/$14,000	$7,000/$14,000	$7,500/$15,000	$6,000/$12,000	$3,500/$7,000	$7,000/$14,000
Non-network out-of-pocket maximum (individual/family)	$21,000/$42,000	$21,000/$42,000	$21,000/$42,000	$22,500/$45,000	$18,000/$36,000	$10,500/$21,000	Not applicable
Office visits: Primary care (PCP)/Specialist (SPC)	PCP: $30 SPC: $60	PCP: $25 SPC: $50	PCP: $30 SPC: $50	PCP: $25 SPC: $50	PCP: $30 SPC: $60	PCP: Deductible, then $25 SPC: Deductible, then $50	PCP: $25 SPC: $60
Online doctor visits: Preferred	$10	$10	$10	$10	$10	Deductible, then $10	$10
Urgent care (facility)[2]	$100	$100	$100	$100	$100	Deductible, then $100	$100
Emergency room (facility)[2]	Deductible, then $400	Deductible, then $400	Deductible, then $400	Deductible, then $450	Deductible, then $450	Deductible, then $400	Deductible, then $400
Outpatient surgery (facility)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	Deductible, then $250	Deductible, then 25% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	Deductible, then $350 per admission	Deductible, then 25% coinsurance
Prescription drugs: network/drug list	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[3] (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: Medical deductible applies	Tiers 1-4: No deductible
Retail pharmacy: 30-day supply[4]	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script
Home delivery pharmacy: 90-day supply	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30%	$38/$150/$270/30% up to $450 per script
Incentive package	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational

* Groups of one are eligible for Small Group plans under certain conditions. For more information, please contact your Anthem representative.

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3

Small Group ACA product details – 2* to 50 employees

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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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	Gold plans						Silver plans
Plan type	HMO			HMO HSA	Healthy Support PPO HSA		PPO
Plan name	Anthem Gold Pathway Group HMO 1000/20%/7000	Anthem Gold Pathway Group HMO 2000/20%/7000	Anthem Gold Pathway Group HMO 2500/0%/7500	Anthem Gold Pathway Group HMO 1500C/0%/3500 w/ HSA$^{\Delta}$	Anthem Gold Blue Access PPO 2000/0%/3000 Plus w/HSA$^{\Delta}$	Anthem Gold Blue Access PPO 2500/10%/4000 Plus w/HSA$^{\Delta}$	Anthem Silver Blue Access PPO 2500/50%/7500
Network	Pathway Group HMO	Pathway Group HMO	Pathway Group HMO	Pathway Group HMO	Blue Access	Blue Access	Blue Access
Deductible[1] (individual/family)	$1,000/$3,000	$2,000/$4,000	$2,500/$5,000	$1,500/$3,000	$2,000/$4,000	$2,500/$5,000	$2,500/$5,000
Non-network deductible (individual/family)	Not applicable	Not applicable	Not applicable	Not applicable	$6,000/$12,000	$7,500/$15,000	$7,500/$15,000
Coinsurance	20%	20%	0%	0%	0%	10%	50%
Non-network coinsurance	Not applicable	Not applicable	Not applicable	Not applicable	30%	40%	50%
Out-of-pocket maximum[1] (individual/family)	$7,000/$14,000	$7,000/$14,000	$7,500/$15,000	$3,500/$7,000	$3,000/$6,000	$4,000/$8,000	$7,500/$15,000
Non-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable	Not applicable	Not applicable	$9,000/$18,000	$12,000/$24,000	$22,500/$45,000
Office visits: Primary care (PCP)/Specialist (SPC)	PCP: $30 SPC: $60	PCP: $30 SPC: $50	PCP: $25 SPC: $50	PCP: Deductible, then $25 SPC: Deductible, then $50	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	PCP: $50 SPC: $80
Online doctor visits: Preferred	$10	$10	$10	Deductible, then $10	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	$10
Urgent care (facility)[2]	$100	$100	$100	Deductible, then $100	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	$100
Emergency room (facility)[2]	Deductible, then $400	Deductible, then $400	Deductible, then $450	Deductible, then $400	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	Deductible, then $500
Outpatient surgery (facility)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then $250	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	Deductible, then 50% coinsurance
Hospital inpatient admission	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance	Deductible, then $350 per admission	Deductible, then 0% coinsurance	Deductible, then 10% coinsurance	Deductible, then 50% coinsurance
Prescription drugs: network/drug list	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[3] (individual/family)	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: No deductible	Tiers 1-4: Medical deductible applies	Tiers 1-4: Medical deductible applies	Tiers 1-4: Medical deductible applies	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible
Retail pharmacy: 30-day supply[4]	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: 10% Level 2: 20%	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script
Home delivery pharmacy: 90-day supply	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30%	$38/$150/$270/30%	10%	$38/$150/$270/30% up to $450 per script
Incentive package	Foundational	Foundational	Foundational	Foundational	Preventive Care Incentives + Fitness	Preventive Care Incentives + Fitness	Foundational

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Small Group ACA product details – 2* to 50 employees

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	Silver plans						
Plan type	PPO						
Plan name	Anthem Silver Blue Access PPO 3000/20%/8000 Focus†	Anthem Silver Blue Access PPO 3500/30%/7500	Anthem Silver Blue Access PPO 4000/20%/8000 Focus†	Anthem Silver Blue Access PPO 4500/30%/7500	Anthem Silver Blue Access PPO 5000/20%/8000 Focus†	Anthem Silver Blue Access PPO 5500/25%/8150	Anthem Silver Blue Access PPO 6000/0%/8000
Network	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access
Deductible[1] (individual/family)	$3,000/$6,000	$3,500/$7,000	$4,000/$8,000	$4,500/$9,000	$5,000/$10,000	$5,500/$11,000	$6,000/$12,000
Non-network deductible (individual/family)	$9,000/$18,000	$10,500/$21,000	$12,000/$24,000	$13,500/$27,000	$15,000/$30,000	$16,500/$33,000	$18,000/$36,000
Coinsurance	20%	30%	20%	30%	20%	25%	0%
Non-network coinsurance	50%	50%	50%	50%	50%	50%	30%
Out-of-pocket maximum[1] (individual/family)	$8,000/$16,000	$7,500/$15,000	$8,000/$16,000	$7,500/$15,000	$8,000/$16,000	$8,150/$16,300	$8,000/$16,000
Non-network out-of-pocket maximum (individual/family)	$24,000/$48,000	$22,500/$45,000	$24,000/$48,000	$22,500/$45,000	$24,000/$48,000	$24,450/$48,900	$24,000/$48,000
Office visits: Primary care (PCP)/Specialist (SPC)	PCP (children up to age 19): $0 PCP (ages 19+): $20 SPC: $50	PCP: $35 SPC: $70	PCP (children up to age 19): $0 PCP (ages 19+): $20 SPC: $50	PCP: $25 SPC: $60	PCP (children up to age 19): $0 PCP (ages 19+): $20 SPC: $50	PCP: $50 SPC: $80	PCP: $35 SPC: $65
Online doctor visits: Preferred	$5	$10	$5	$10	$5	$10	$10
Urgent care (facility)[2]	$100	$100	$100	$100	$100	$100	$100
Emergency room (facility)[2]	$250, then deductible, then 20% coinsurance	Deductible, then $500	$250, then deductible, then 20% coinsurance	Deductible, then $500	$250, then deductible, then 20% coinsurance	Deductible, then $500	Deductible, then $500
Outpatient surgery (facility)	$250, then deductible, then 20% coinsurance	Deductible, then 30% coinsurance	$250, then deductible, then 20% coinsurance	Deductible, then 30% coinsurance	$250, then deductible, then 20% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Hospital inpatient admission	$250, then deductible, then 20% coinsurance per admission	Deductible, then 30% coinsurance	$250, then deductible, then 20% coinsurance per admission	Deductible, then 30% coinsurance	$250, then deductible, then 20% coinsurance per admission	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Prescription drugs: network/drug list	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[3] (individual/family)	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: $250/$500 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: $250/$500 Pharmacy deductible	Tier 1: No deductible Tiers 2-4: $250/$500 Pharmacy deductible
Retail pharmacy: 30-day supply[4]	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $550 per script Level 2: $25/$60/$100/30% up to $650 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script
Home delivery pharmacy: 90-day supply	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $550 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script
Incentive package	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational

* Groups of one are eligible for Small Group plans under certain conditions. For more information, please contact your Anthem representative.

△ Nonembedded deductible and out-of-pocket maximum plan; all other plans have embedded deductibles and out-of-pocket maximums.

† Focus plans have no PCP office visit copay for children under age 19.

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2 Some services received in an urgent care and emergency room setting are subject to deductible and applicable copay/coinsurance.

3 For plans where the medical deductible applies to covered prescription drugs, the network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, the non-network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at non-network pharmacies (retail only). For plans with a separate pharmacy deductible, this deductible applies to covered prescription drugs (in the tiers noted) obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, it also applies to covered prescription drugs obtained at non-network pharmacies (retail only).

4 Retail 90 (R90) is included on all plans. Employees can get a 90-day supply of maintenance medications from a participating retail pharmacy.

5

Small Group ACA product details – 2* 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 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						
Plan type	PPO	PPO HSA			HMO		HMO HSA
Plan name	Anthem Silver Blue Access PPO 6000/30%/7200	Anthem Silver Blue Access PPO 3000EC/0%/5500 w/HSA	Anthem Silver Blue Access PPO 3000EC/10%/5000 w/HSA	Anthem Silver Blue Access PPO 4000E/20%/6500 w/HSA	Anthem Silver Pathway Group HMO 2500/50%/7500	Anthem Silver Pathway Group HMO 6000/0%/8000	Anthem Silver Pathway Group HMO 3000EC/0%/5500 w/HSA
Network	Blue Access	Blue Access	Blue Access	Blue Access	Pathway Group HMO	Pathway Group HMO	Pathway Group HMO
Deductible[1] (individual/family)	$6,000/$12,000	$3,000/$6,000	$3,000/$6,000	$4,000/$8,000	$2,500/$5,000	$6,000/$12,000	$3,000/$6,000
Non-network deductible (individual/family)	$18,000/$36,000	$9,000/$18,000	$9,000/$18,000	$12,000/$24,000	Not applicable	Not applicable	Not applicable
Coinsurance	30%	0%	10%	20%	50%	0%	0%
Non-network coinsurance	50%	30%	40%	50%	Not applicable	Not applicable	Not applicable
Out-of-pocket maximum[1] (individual/family)	$7,200/$14,400	$5,500/$11,000	$5,000/$10,000	$6,500/$13,000	$7,500/$15,000	$8,000/$16,000	$5,500/$11,000
Non-network out-of-pocket maximum (individual/family)	$21,600/$43,200	$16,500/$33,000	$15,000/$30,000	$19,500/$39,000	Not applicable	Not applicable	Not applicable
Office visits: Primary care (PCP)/Specialist (SPC)	PCP: $60 SPC: $90	PCP: Deductible, then $30 SPC: Deductible, then $60	PCP: Deductible, then $25 SPC: Deductible, then $50	Deductible, then 20% coinsurance	PCP: $50 SPC: $80	PCP: $35 SPC: $65	PCP: Deductible, then $30 SPC: Deductible, then $60
Online doctor visits: Preferred	$10	Deductible, then $10	Deductible, then $10	Deductible, then 20% coinsurance	$10	$10	Deductible, then $10
Urgent care (facility)[2]	$100	Deductible, then $100	Deductible, then $100	Deductible, then 20% coinsurance	$100	$100	Deductible, then $100
Emergency room (facility)[2]	Deductible, then $500	Deductible, then $600	Deductible, then $500	Deductible, then 20% coinsurance	Deductible, then $500	Deductible, then $500	Deductible, then $600
Outpatient surgery (facility)	Deductible, then 30% coinsurance	Deductible, then $300	Deductible, then $300	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Deductible, then 0% coinsurance	Deductible, then $300
Hospital inpatient admission	Deductible, then 30% coinsurance	Deductible, then $500 per admission	Deductible, then $500 per admission	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Deductible, then 0% coinsurance	Deductible, then $500 per admission
Prescription drugs: network/drug list	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[3] (individual/family)	Tier 1: No deductible Tiers 2-4: Medical deductible applies	Tiers 1-4: Medical deductible applies	Tiers 1-4: Medical deductible applies	Tiers 1-4: Medical deductible applies	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
Retail pharmacy: 30-day supply[4]	Level 1: $25/$50/$90/30% up to $550 per script Level 2: $35/$60/$100/30% up to $650 per script	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: 20% Level 2: 30%	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% up to $450 per script Level 2: $25/$60/$100/30% up to $550 per script	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%
Home delivery pharmacy: 90-day supply	$63/$150/$270/30% up to $550 per script	$38/$150/$270/30%	$38/$150/$270/30%	20%	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30% up to $450 per script	$38/$150/$270/30%
Incentive package	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational

* Groups of one are eligible for Small Group plans under certain conditions. For more information, please contact your Anthem representative.

△ Nonembedded deductible and out-of-pocket maximum plan; all other plans have embedded deductibles and out-of-pocket maximums.

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1 Here's an overview of nonembedded versus embedded accumulator plans: A nonembedded plan means all family members share a deductible and out-of-pocket (OOP) maximum, regardless of the number of family members. The entire deductible must be met before any one family member receives benefits, and the entire OOP must be met before the family has satisfied the OOP maximum. An embedded plan 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. Similarly, any cost-sharing contributed by an individual family member applies to the family OOP maximum, but no individual family member contributes more to the family OOP maximum than their individual OOP maximum amount.

2 Some services received in an urgent care and emergency room setting are subject to deductible and applicable copay/coinsurance.

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4 Retail 90 (R90) is included on all plans. Employees can get a 90-day supply of maintenance medications from a participating retail pharmacy.

6

Small Group ACA product details – 2* 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 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				Bronze plans		
Plan type	HMO HSA		Healthy Support PPO HSA		PPO		PPO HSA
Plan name	Anthem Silver Pathway Group HMO 3500E/0%/6000 w/HSA	Anthem Silver Pathway Group HMO 5000E/0%/6850 w/HSA	Anthem Silver Blue Access PPO 3500E/0%/6000 Plus w/HSA	Anthem Silver Blue Access PPO 5000E/0%/6850 Plus w/HSA	Anthem Bronze Blue Access PPO 7000/25%/8150	Anthem Bronze Blue Access PPO 7500/25%/8150	Anthem Bronze Blue Access PPO 4500E/50%/6850 w/HSA
Network	Pathway Group HMO	Pathway Group HMO	Blue Access	Blue Access	Blue Access	Blue Access	Blue Access
Deductible[1] (individual/family)	$3,500/$7,000	$5,000/$10,000	$3,500/$7,000	$5,000/$10,000	$7,000/$14,000	$7,500/$15,000	$4,500/$9,000
Non-network deductible (individual/family)	Not applicable	Not applicable	$10,500/$21,000	$15,000/$30,000	$21,000/$42,000	$22,500/$45,000	$13,500/$27,000
Coinsurance	0%	0%	0%	0%	25%	25%	50%
Non-network coinsurance	Not applicable	Not applicable	30%	30%	50%	50%	50%
Out-of-pocket maximum[1] (individual/family)	$6,000/$12,000	$6,850/$13,700	$6,000/$12,000	$6,850/$13,700	$8,150/$16,300	$8,150/$16,300	$6,850/$13,700
Non-network out-of-pocket maximum (individual/family)	Not applicable	Not applicable	$18,000/$36,000	$20,550/$41,100	$24,450/$48,900	$24,450/$48,900	$20,550/$41,100
Office visits: Primary care (PCP)/Specialist (SPC)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	PCP: $60 SPC: $90	Deductible, then 50% coinsurance
Online doctor visits: Preferred	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	$10	Deductible, then 50% coinsurance
Urgent care (facility)[2]	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	$100	Deductible, then 50% coinsurance
Emergency room (facility)[2]	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	Deductible, then $600	Deductible, then 50% coinsurance
Outpatient surgery (facility)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Hospital inpatient admission	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 50% coinsurance
Prescription drugs: network/drug list	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[3] (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	Tier 1: No deductible Tiers 2-4: Medical deductible applies	Tiers 1-4: Medical deductible applies
Retail pharmacy: 30-day supply[4]	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% up to $550 per script Level 2: $25/$60/$100/30% up to $650 per script	Level 1: $25/$50/$90/30% up to $550 per script Level 2: $35/$60/$100/30% up to $650 per script	Level 1: 40% Level 2: 50%
Home delivery pharmacy: 90-day supply	$38/$150/$270/30%	$38/$150/$270/30%	$38/$150/$270/30%	$38/$150/$270/30%	$38/$150/$270/30% up to $550 per script	$63/$150/$270/30% up to $550 per script	40%
Incentive package	Foundational	Foundational	Preventive Care Incentives + Fitness	Preventive Care Incentives + Fitness	Foundational	Foundational	Foundational

* Groups of one are eligible for Small Group plans under certain conditions. For more information, please contact your Anthem representative.

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2 Some services received in an urgent care and emergency room setting are subject to deductible and applicable copay/coinsurance.

3 For plans where the medical deductible applies to covered prescription drugs, the network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, the non-network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at non-network pharmacies (retail only). For plans with a separate pharmacy deductible, this deductible applies to covered prescription drugs (in the tiers noted) obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, it also applies to covered prescription drugs obtained at non-network pharmacies (retail only).

4 Retail 90 (R90) is included on all plans. Employees can get a 90-day supply of maintenance medications from a participating retail pharmacy.

7

Small Group ACA product details – 2* 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 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	PPO HSA			HMO	HMO HSA		
Plan name	Anthem Bronze Blue Access PPO 5000E/10%/6850 w/HSA	Anthem Bronze Blue Access PPO 5500EC/0%/6850 w/HSA	Anthem Bronze Blue Access PPO 6000EC/20%/6850 w/HSA	Anthem Bronze Pathway Group HMO 7000/25%/8150	Anthem Bronze Pathway Group HMO 5000E/10%/6850 w/HSA	Anthem Bronze Pathway Group HMO 5500EC/0%/6850 w/HSA	Anthem Bronze Pathway Group HMO 6250E/0%/6850 w/HSA
Network	Blue Access	Blue Access	Blue Access	Pathway Group HMO	Pathway Group HMO	Pathway Group HMO	Pathway Group HMO
Deductible[1] (individual/family)	$5,000/$10,000	$5,500/$11,000	$6,000/$12,000	$7,000/$14,000	$5,000/$10,000	$5,500/$11,000	$6,250/$12,500
Non-network deductible (individual/family)	$15,000/$30,000	$16,500/$33,000	$18,000/$36,000	Not applicable	Not applicable	Not applicable	Not applicable
Coinsurance	10%	0%	20%	25%	10%	0%	0%
Non-network coinsurance	40%	30%	50%	Not applicable	Not applicable	Not applicable	Not applicable
Out-of-pocket maximum[1] (individual/family)	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700	$8,150/$16,300	$6,850/$13,700	$6,850/$13,700	$6,850/$13,700
Non-network out-of-pocket maximum (individual/family)	$20,550/$41,100	$20,550/$41,100	$20,550/$41,100	Not applicable	Not applicable	Not applicable	Not applicable
Office visits: Primary care (PCP)/Specialist (SPC)	Deductible, then 10% coinsurance	PCP: Deductible, then $35 SPC: Deductible, then $70	PCP: Deductible, then $30 SPC: Deductible, then $60	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	PCP: Deductible, then $35 SPC: Deductible, then $70	Deductible, then 0% coinsurance
Online doctor visits: Preferred	Deductible, then 10% coinsurance	Deductible, then $10	Deductible, then $10	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then $10	Deductible, then 0% coinsurance
Urgent care (facility)[2]	Deductible, then 10% coinsurance	Deductible, then $100	Deductible, then $100	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then $100	Deductible, then 0% coinsurance
Emergency room (facility)[2]	Deductible, then 10% coinsurance	Deductible, then $600	Deductible, then $600	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then $600	Deductible, then 0% coinsurance
Outpatient surgery (facility)	Deductible, then 10% coinsurance	Deductible, then $500	Deductible, then $500	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then $500	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 10% coinsurance	Deductible, then $750 per admission	Deductible, then $750 per admission	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then $750 per admission	Deductible, then 0% coinsurance
Prescription drugs: network/drug list	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[3] (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	Tiers 1-4: Medical deductible applies	Tiers 1-4: Medical deductible applies
Retail pharmacy: 30-day supply[4]	Level 1: 10% Level 2: 20%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% up to $550 per script Level 2: $25/$60/$100/30% up to $650 per script	Level 1: 10% Level 2: 20%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%
Home delivery pharmacy: 90-day supply	10%	$38/$150/$270/30%	$38/$150/$270/30%	$38/$150/$270/30% up to $550 per script	10%	$38/$150/$270/30%	$38/$150/$270/30%
Incentive package	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational	Foundational

* Groups of one are eligible for Small Group plans under certain conditions. For more information, please contact your Anthem representative.

△ Nonembedded deductible and out-of-pocket maximum plan; all other plans have embedded deductibles and out-of-pocket maximums.

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2 Some services received in an urgent care and emergency room setting are subject to deductible and applicable copay/coinsurance.

3 For plans where the medical deductible applies to covered prescription drugs, the network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, the non-network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at non-network pharmacies (retail only). For plans with a separate pharmacy deductible, this deductible applies to covered prescription drugs (in the tiers noted) obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, it also applies to covered prescription drugs obtained at non-network pharmacies (retail only).

4 Retail 90 (R90) is included on all plans. Employees can get a 90-day supply of maintenance medications from a participating retail pharmacy.

8

Small Group ACA product details – 2* 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 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	Healthy Support PPO HSA
Plan name	Anthem Bronze Blue Access PPO 6250E/0%/6850 Plus w/HSA
Network	Blue Access
Deductible[1] (individual/family)	$6,250/$12,500
Non-network deductible (individual/family)	$18,750/$37,500
Coinsurance	0%
Non-network coinsurance	30%
Out-of-pocket maximum[1] (individual/family)	$6,850/$13,700
Non-network out-of-pocket maximum (individual/family)	$20,550/$41,100
Office visits: Primary care (PCP)/Specialist (SPC)	Deductible, then 0% coinsurance
Online doctor visits: Preferred	Deductible, then 0% coinsurance
Urgent care (facility)[2]	Deductible, then 0% coinsurance
Emergency room (facility)[2]	Deductible, then 0% coinsurance
Outpatient surgery (facility)	Deductible, then 0% coinsurance
Hospital inpatient admission	Deductible, then 0% coinsurance
Prescription drugs: network/drug list	Rx Choice Tiered Network with R90/Select
Pharmacy deductible[3] (individual/family)	Tiers 1-4: Medical deductible applies
Retail pharmacy: 30-day supply[4]	Level 1: $15/$50/$90/30% Level 2: $25/$60/$100/40%
Home delivery pharmacy: 90-day supply	$38/$150/$270/30%
Incentive package	Preventive Care Incentives + Fitness

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△ Nonembedded deductible and out-of-pocket maximum plan; all other plans have embedded deductibles and out-of-pocket maximums.

† Focus plans have no PCP office visit copay for children under age 19.

1 Here's an overview of nonembedded versus embedded accumulator plans: A nonembedded plan means all family members share a deductible and out-of-pocket (OOP) maximum, regardless of the number of family members. The entire deductible must be met before any one family member receives benefits, and the entire OOP must be met before the family has satisfied the OOP maximum. An embedded plan 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. Similarly, any cost-sharing contributed by an individual family member applies to the family OOP maximum, but no individual family member contributes more to the family OOP maximum than their individual OOP maximum amount.

2 Some services received in an urgent care and emergency room setting are subject to deductible and applicable copay/coinsurance.

3 For plans where the medical deductible applies to covered prescription drugs, the network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, the non-network medical deductible and out-of-pocket maximum apply to covered prescription drugs obtained at non-network pharmacies (retail only). For plans with a separate pharmacy deductible, this deductible applies to covered prescription drugs (in the tiers noted) obtained at Level 1 pharmacies (retail and home delivery) and Level 2 pharmacies (retail only). For PPO plans, it also applies to covered prescription drugs obtained at non-network pharmacies (retail only).

4 Retail 90 (R90) is included on all plans. Employees can get a 90-day supply of maintenance medications from a participating retail pharmacy.

9

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

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. ***HMO plans only:*** Services from a provider that is not in our network. This does not apply to emergency care or authorized services.
2. Which we determine are not medically necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines.
3. Services members get from providers that are not licensed by law to provide covered services as defined in the Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
4. Which are experimental / investigative or related to such, whether incurred prior to, in connection with, or subsequent to the experimental / investigative service or supply, as determined by Anthem. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be experimental / investigative.
5. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to the member, then this exclusion does not apply. ***PPO plans only:*** This exclusion applies if the member receives the benefits in whole or in part. This exclusion also applies whether or not members claim the benefits or compensation. It also applies whether or not members recover from any third party.
6. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
7. ***PPO plans only:*** For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
8. ***PPO plans only:*** For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
9. For court ordered testing or care unless medically necessary.
10. For which members have no legal obligation to pay in the absence of this or like coverage.
11. For the following:
    a. Physician or other practitioners' charges for consulting with members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the member except as otherwise described in the Booklet.
    b. Surcharges for furnishing and/or receiving medical records and reports.
    c. Charges for doing research with providers not directly responsible for a member's care.
    d. Charges that are not documented in provider records.
    e. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending doctor.
    f. For membership, administrative, or access fees charged by doctors or other providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
12. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group. This exclusion does not apply to covered services that have not been exhausted; and, are not paid for by another source.
13. Prescribed, ordered or referred by or received from a member of the member's immediate family, including spouse, child, brother, sister, parent, in-law, or self.
14. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
15. For missed or canceled appointments.
16. For mileage, lodging and meals costs, and other member travel related expenses, except as authorized by Anthem or specifically stated as a covered service.
17. 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 "General Provisions." If a member does not enroll in Medicare Part B, when eligible, we will calculate benefits as if the member had enrolled. Members should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
18. Charges in excess of our maximum allowable amounts.
19. Incurred prior to the member's effective date.
20. Incurred after the termination date of this coverage except as specified elsewhere in the Booklet.
21. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for social reasons. No benefits are available for surgery or treatments to change the texture or appearance of a member's skin or to change the size, shape or appearance of facial or body features (such as nose, eyes, ears, cheeks, chin, chest or breasts). ***PPO plans only:*** Complications directly related to cosmetic services treatment or surgery, as determined by Anthem, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the member was covered by another carrier/self-funded plan prior to coverage under the Booklet. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
22. ***PPO plans only:*** For maintenance therapy, which is 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.
23. For custodial care, convalescent care or rest cures.

24. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including, but not limited to:
    a. cleaning and soaking the feet.
    b. applying skin creams in order to maintain skin tone.
    c. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
25. For foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
26. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
27. For dental treatment, under the medical portion of this plan, regardless of origin or cause, except as specified elsewhere in the Booklet. "Dental treatment" includes, but is not limited to: preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a covered service) or gums, including, but not limited to:
    a. extraction, restoration and replacement of teeth.
    b. medical or surgical treatments of dental conditions.
    c. services to improve dental clinical outcomes.
    d. This exclusion does not apply to covered dental services for members through age 18.
28. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a covered service.
29. For the following dental services:
    a. Dental care for members age 19 and older, unless covered by the medical benefits of the Booklet.
    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 Booklet (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 the Booklet or received after the coverage under the Booklet has ended.
    e. 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.
    f. Analgesia, analgesia agents, oral sedation and anxiolysis nitrous oxide.
    g. Services of anesthesiologist, unless required by law.
    h. Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
    i. Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including, but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
    j. 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.
    k. Case presentations, office visits.
    l. Enamel microabrasion and odontoplasty.
    m. Additional, elective or enhanced prosthodontic procedures including, but not limited to, connector bar(s), stress breakers and precision attachments.
    n. Provisional splinting.
    o. Cone beam images.
    p. Anatomical crown exposure.
    q. Temporary anchorage devices.
    r. Sinus augmentation.
    s. Temporomandibular joint disorder (TMJ), unless covered by the medical benefits of the Booklet.
    t. Oral hygiene instructions.
    u. Repair or replacement of lost or broken appliances.
    v. Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
    w. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    x. Separate services billed when they are an inherent component of another covered service.
    y. Dental services for which members would have no legal obligation to pay in the absence of this or like coverage.
    z. Additional treatment necessary to correct or relieve the results of treatment previously benefited under the Booklet.
    aa. Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of the Booklet.
    ab. Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of the Booklet.
    ac. Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannon satisfactorily restore the case.
    ad. Pulp vitality tests.
    ae. 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).
    af. Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
    ag. The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
    ah. Oral appliances for snoring
30. For dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified elsewhere in the Booklet. The only exceptions to this are for any of the following:
    a. transplant preparation.
    b. initiation of immunosuppresives.
    c. treatment related to an accidental injury, cancer or cleft palate.
31. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as specified elsewhere in the Booklet.
32. Weight loss programs whether or not they are pursued under medical or doctor supervision, unless specifically 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. This exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.
33. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes, but is not limited to, Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce 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,

(surgical procedures that decrease the size of the stomach), or gastric banding procedures. ***PPO plans only:*** Complications directly related to bariatric surgery that result in an inpatient stay or an extended inpatient stay for the bariatric surgery, as determined by Anthem, are not covered. This exclusion applies when the bariatric surgery was not a covered service under this plan or any previous Anthem plan, and it applies if the surgery was performed while the member was covered by a previous carrier/self-funded plan prior to coverage under the Booklet. Directly related means that the inpatient stay or extended inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

34. For marital counseling.
35. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a covered service for members through age 18. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
36. For vision orthoptic training.
37. For 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.
38. For 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, except as otherwise specified herein.
39. For services to reverse voluntarily induced sterility.
40. ***HMO plans only:*** For experimental infertility procedures and non-medically necessary procedures including, but not limited to, artificial insemination, in-vitro fertilization ("IVF"), gamete intrafallopian transfer ("GIFT"), fertility drugs and zygote intrafallopian transfer ("ZIFT").
41. ***PPO plans only:*** For diagnostic testing or treatment related to infertility.
42. For personal hygiene, environmental control, or convenience items including, but not limited to:
    a. Air conditioners, humidifiers, air purifiers;
    b. Personal comfort and convenience items during an inpatient stay, including, but not limited to, daily television rental, telephone services, cots or visitor's meals;
    c. Charges for non-medical self-care except as otherwise stated;
    d. Purchase or rental of supplies for common household use, such as water purifiers;
    e. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    f. Infant helmets to treat positional plagiocephaly;
    g. Safety helmets for members with neuromuscular diseases; or
    h. Sports helmets; or
    i. Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications
43. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.
44. For telephone consultations or consultations via electronic mail or internet/website, except as required by law, authorized by Anthem, or as otherwise described in the Booklet.
45. For care received in an emergency room which is not emergency care, except as specified in the Booklet. For non-emergency care members should use the closest network urgent care center and/or their primary care physician for services. As required by Ohio law, please note that coverage for emergency care will be provided as described in "Emergency Care Services" in the Covered Services section. Examples of non-emergency care may include, but are not limited to: suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, and dental caries/cavity.
46. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
47. For self-help training and other forms of non-medical self care, except as otherwise provided in the Booklet.
48. For examinations relating to research screenings.
49. For stand-by charges of a doctor.
50. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.***PPO plans only:*** This exclusion does not apply to covered services that have not been exhausted and are not paid for by another source.
51. For private duty nursing services rendered in a hospital or skilled nursing facility; private duty nursing services are covered services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
52. For manipulation therapy services rendered in the home as part of Home Care Services.
53. Services and supplies related male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
54. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
55. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
56. For surgical treatment of gynecomastia.
57. For medical and surgical treatment of hyperhidrosis (excessive sweating).
58. For any service for which members are responsible under the terms of the Booklet to pay a copay, coinsurance or deductible, and the copay, coinsurance or deductible is waived by an non-network provider.
59. 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.
60. ***PPO plans only:*** Complications of/or services directly related to services, supplies, or treatment related to or for problems that is a non-covered service under the Booklet because it was determined by Anthem to be experimental/investigational or non-medically necessary. Directly related means that the

service or treatment occurred as a direct result of the experimental/investigational or non-medically necessary service and would not have taken place in the absence of the experimental/investigational or non-medically necessary service.

61. For drugs, devices, products, or supplies with over-the-counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter drug, device, product, or supply. This exclusion does not apply to preventive services and over-the-counter products that we must cover under federal law with a prescription.
62. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
63. Treatment of telangiectatic dermal veins (spider veins) by any method.
64. Reconstructive services except as specifically stated in the "What's Covered" section of the Booklet, or as required by law.
65. Nutritional and/or dietary supplements, except as provided in the Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to covered services received for home infusion therapy under the "Home Care Services" benefit.
66. For 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 annon-network provider.
67. For applied behavioral treatment (including, but not limited to, applied behavior analysis and intensive behavior interventions) for all indications except as described under Habilitative Services in the "What's Covered" section unless otherwise required by law.
68. For certain prescription drugs if a 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.
69. For 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.
70. Drugs not approved by the FDA.
71. For 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.
72. For delivery charges for delivery of prescription drugs.
73. For drugs in quantities which are over the limits set by the plan, or which are over any age limits set by us.
74. For drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
75. For 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.
76. For prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by us.
77. For drugs given to members or prescribed in a way that is against approved medical and professional standards of practice.
78. For 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.
79. For refills of lost or stolen drugs.
80. For residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility, or residential treatment center.
81. For services rendered by providers located outside the United States, unless the services are for emergency care and emergency ambulance.
82. For 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.
83. For 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.
84. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
85. For autopsies and post-mortem testing.
86. For 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.
87. For charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
88. 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.

89. 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.
90. For wilderness or other outdoor camps and/or programs.
91. Services from a facility or residential treatment center / facility that do not fall within the definitions of "Facility" or "Residential Treatment Center / Facility" listed in the "Definitions" section of the Booklet.
92. For the following vision services:
    a. Eyeglass lenses, frames, or contact lenses for members age 19 and older, unless listed as covered in this booklet.
    b. Visual therapy, such as orthoptics or vision training, and any associated supplemental testing, unless covered under the medical benefits in the Booklet.
    c. For two pairs of glasses in lieu of bifocals.
    d. For plano lenses (lenses that have no refractive power).
    e. For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, unless covered by the medical benefits of the {Booklet.
    f. Lost or broken lenses or frames, unless the member has reached the member's normal interval for service when seeking replacements.
    g. Cosmetic lens options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in the Booklet.
    h. Safety glasses and accompanying frames.
    i. Vision services not listed as covered in the Booklet.
    j. 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.
    k. For members through age 18, no benefits are available for frames or contact lenses not on the Anthem formulary.
    l. Certain benefits may be covered under the "Preventive Care" benefit. Please see that section for further details.
    m. ***HMO plans only:*** For vision care received out of network.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health problem which we decide in our sole discretion to be experimental or investigational is not covered by your plan.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be experimental or investigational if we decide that one of more of the criteria listed below apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is given because of informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational, or otherwise show that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed experimental or investigational based on the criteria above may still be deemed experimental or investigational by us. In deciding whether a service is experimental or investigational, we will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s)used by the treating doctors, other medical professionals, or facilities or by other treating doctors, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting providers and other experts in the field.

We have the sole authority and discretion, when allowed by state law, to identify and weigh all information and decide all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is experimental or investigational.

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

In addition to the exclusions in the "What's Not Covered" section of the Booklet, certain items are not covered under the prescription drug retail or home delivery (mail order) pharmacy benefit:

1. Prescription drugs dispensed by any mail service program other than the PBM's home delivery pharmacy, unless prohibited by law.
2. 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 if 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 we must cover as a "Preventive Care" benefit under federal law with a prescription.

3. Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original prescription order.
4. Drugs not approved by the FDA.
5. Charges for the administration of any drug.
6. Drugs consumed at the time and place where dispensed or where the prescription order is issued, including, but not limited to, samples provided by a doctor. This does not apply to drugs used in conjunction with a diagnostic service, with chemotherapy performed in the office or drugs eligible for coverage under the Medical Supplies benefit; they are covered services.
7. Any drug which is primarily for weight loss.
8. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to preventive services and over-the-counter products that we must cover under federal law with a prescription.
9. Drugs which are over any quantity or age limits set by the plan or us.
10. Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
11. Fertility drugs.
12. Drugs in quantities which exceed the limits established by the plan.
13. Human Growth Hormone for children born small for gestational age. It is only a covered service in other situations when allowed by Anthem through prior authorization.
14. 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. Treatment of onchomycosis (toenail fungus).
16. Certain prescription legend drugs are not covered services when any version or strength becomes available over the counter. Please contact Anthem for additional information on these drugs.
17. Refills of lost or stolen medications.
18. Drugs not on the Anthem prescription drug list (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.
19. For prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications, as determined by us.
20. For gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
21. For charges for services not described in the member's medical records.
22. Services prescribed, ordered, referred by or given by a member of the member's immediate family, including spouse, child, brother, sister, parent, in-law, or self.
23. Services we conclude are not medically necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
24. 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.

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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