

Anthem HealthKeepers 10 POS

Covered Services	You Pay
Preventive Care Services	
<p>Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.</p> <p>*During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.</p>	*No Charge
Doctor Visits	
<ul style="list-style-type: none"> ○ office visits ○ home visits ○ urgent care visits ○ in-office surgery ○ voluntary family planning 	<p>\$10 for each visit to your PCP \$20 for each visit to a specialist</p>
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
<ul style="list-style-type: none"> ○ diagnostic x-rays ○ diagnostic tests ○ lab work <p>A copay does not apply when these services are provided by the same provider on the same day as the office visit.</p>	<p>\$10 for each visit to your PCP \$20 for each visit to a specialist</p>
<ul style="list-style-type: none"> ○ advanced diagnostic imaging services 	<p>10% of the amount the health care professionals in our network have agreed to accept for their services</p>
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
<ul style="list-style-type: none"> ○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> ○ behavioral health treatment* ○ psychiatric care ○ therapeutic care** ○ pharmacy care ○ psychological care <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	<p>Member cost shares will be dependent on the services rendered.</p>
<ul style="list-style-type: none"> ○ applied behavioral analysis <ul style="list-style-type: none"> ○ unlimited per member annual maximum 	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Early Intervention – For children from birth up to age 3	
<ul style="list-style-type: none"> ○ Unlimited per member per calendar year up to age 3 	<p>Member cost shares will be dependent on the services rendered.</p>
Other Outpatient Services	
<ul style="list-style-type: none"> ○ hospice care 	No Charge
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	<p>Member cost shares will be dependent on the services rendered.</p>
<ul style="list-style-type: none"> ○ ambulance travel 	\$100 per transport
<ul style="list-style-type: none"> ○ home health care (100 visits) 	<p>10% of the amount the health care professionals in our network have agreed to accept for their services</p>
<ul style="list-style-type: none"> ○ prosthetic devices ○ durable medical equipment ○ injectable medication*(excluding immunizations, preventive care, allergy injections and serum dispensed in a physician's office) <p>*You will also pay an additional \$10 or \$20 office visit copayment depending on the type of provider who treats you.</p>	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-plan).

Covered Services	You Pay
Therapy Services	
<ul style="list-style-type: none"> ○ chemotherapy, radiation, cardiac and respiratory therapy ○ physical and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* ○ spinal manipulation and manual medical therapy services (30 visit limit) <p><i>* Limit does not apply to Autism Spectrum Disorder.</i></p>	\$20 for each visit
<ul style="list-style-type: none"> ○ dialysis 	20% of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Infusion Services	
<ul style="list-style-type: none"> ○ facility ○ ambulatory infusion centers 	\$20 for each visit
<ul style="list-style-type: none"> ○ home services 	10% of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Surgery in a Hospital or Facility	
<ul style="list-style-type: none"> ○ surgery 	\$150 for each visit
Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room ○ private room when approved when approved in advance ○ intensive or coronary care unit <p><i>*You do not have to pay another inpatient copay if you are readmitted for the same or related condition within less than 72 hours from when you went home.</i></p>	\$250 per admission*
<ul style="list-style-type: none"> ○ skilled nursing facility (100 days for each admission) 	10% of the amount the health care professionals in our network have agreed to accept for their services
Maternity	
<ul style="list-style-type: none"> ○ all routine pre- and postnatal care (excluding inpatient stays) 	\$150 per pregnancy
<ul style="list-style-type: none"> ○ diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures) 	\$20 for each visit
Outpatient Mental Health and Substance Use	
<ul style="list-style-type: none"> ○ partial day mental health and substance use services 	No charge
<ul style="list-style-type: none"> ○ medication management ○ individual therapy up to 30 minutes in length ○ group therapy ○ other mental health and substance use visits 	\$20 for each visit
Routine Vision	
<ul style="list-style-type: none"> ○ an annual routine eye exam <p><i>Plus valuable discounts on eyewear</i></p>	\$15 for each visit
Emergency Care and Out of the Service Area Urgent Care	
<ul style="list-style-type: none"> ○ urgent care visits 	\$20 for each visit
<ul style="list-style-type: none"> ○ true emergency care visits in or out of the service area <p><i>*Waived if admitted directly to the hospital.</i></p>	\$150 for each visit to an emergency room*
Out-of-Plan Services	
Deductible for services received from out-of-plan health care professionals	
You will pay all of the costs associated with covered services until you pay \$300 in one calendar year.	
<ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay the first \$300 of the cost of your care (\$600 total). ○ If three or more people are covered under your plan, together you will pay the first \$600 of the cost of your care. However, the most one family member will pay is \$300. 	
Once this amount has been reached, we will pay 70% of the amount doctors, hospitals and other health care professionals have agreed to accept for the same covered services.	
If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$300 calendar year out-of-plan deductible) and you will pay the rest of what the professional charges.	
In addition, you may seek spinal manipulation and manual medical therapy services (chiropractic care) from a provider not in our network without first meeting the out-of-plan deductible.	

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using in-plan professionals

If you are the only one covered by your plan, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).
- If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.

When using out-of-plan professionals

If you are the only one covered by your plan, you will pay \$4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).
- If three or more people are covered under your plan, together you will pay \$8,000. However, no family member will pay more than \$4,000 toward the limit.

The following do not count toward the calendar year out-of-pocket maximum:

- your share of the cost of adult routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.

*This benefits overview insert is only one piece of your entire enrollment package.
See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits

Anthem KeyCare 10

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	No charge
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <i>Plus valuable discounts on eyewear</i> 	\$15 for each visit
Doctor Visits	
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ in-office surgery ○ physical and occupational therapy in an office setting (30 combined visits)* ○ speech therapy visits in an office setting (30 visit limit)* ○ spinal manipulations and other manual medical intervention visits (30 visit limit) <p><i>*Limit does not apply to Autism Spectrum Disorder.</i></p>	\$20 for each visit to a PCP \$40 for each visit to a specialist
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
<ul style="list-style-type: none"> ○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> ○ behavioral health treatment* ○ psychiatric care ○ therapeutic care** ○ pharmacy care ○ psychological care <p><i>* Mental Health Services</i> <i>**Unlimited physical, occupational and speech therapy.</i></p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ applied behavioral analysis <ul style="list-style-type: none"> ○ unlimited per member annual maximum 	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
<ul style="list-style-type: none"> ○ unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Labs, Diagnostic X-rays and Other Outpatient Services	
<ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays ○ dialysis ○ infusion services ○ shots and therapeutic injections, including infusion medications ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy 	10% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ durable medical equipment ○ medical appliances, supplies and medications 	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ ambulance travel 	\$100 per transport
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit (whether received in or out-of-network).

In-Network Services	You Pay
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* <p><i>*Limit does not apply to Autism Spectrum Disorder.</i></p>	<p>\$40 plus 10% of the amount the health care professionals in our network have agreed to accept for their services</p>
<ul style="list-style-type: none"> ○ surgery <p><i>*For the services billed by the doctor, you will pay an additional \$10 or \$20 depending on the type of doctor who treats you.</i></p>	<p>\$100 plus 10% of the amount the health care professionals in our network have agreed to accept for their services*</p>
Emergency Care	
<ul style="list-style-type: none"> ○ emergency room 	<p>\$150 plus 10% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ emergency room physician services 	<p>10% of the amount the health care professionals in our network have agreed to accept for their services</p>
Mental Health and Substance Use Outpatient Services	
<ul style="list-style-type: none"> ○ office visits 	<p>\$20 per visit</p>
<ul style="list-style-type: none"> ○ outpatient facility (including partial day mental health and substance use services) ○ outpatient facility professional provider services 	<p>10% of the amount the health care professionals in our network have agreed to accept for their services</p>
Care at Home	
<ul style="list-style-type: none"> ○ hospice care 	<p>No charge</p>
<ul style="list-style-type: none"> ○ home health care (100 visits) 	<p>10% of the amount the health care professionals in our network have agreed to accept for their services</p>
<ul style="list-style-type: none"> ○ private duty nursing limited to 16 hours per member per calendar year* <p><i>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.</i></p>	<p>20% of the amount the health care professionals in our network have agreed to accept for their services</p>
Maternity	
<ul style="list-style-type: none"> ○ all routine pre- and postnatal care (excluding inpatient stays) 	<p>\$150 per pregnancy</p>
<ul style="list-style-type: none"> ○ diagnostic test ○ non-stress tests and other fetal monitor procedures ○ ultrasounds 	<p>10% of the amount the health care professionals in our network have agreed to accept for their services</p>
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit <p><i>*You do not have to pay another inpatient copay if you are readmitted for the same or related condition within 90 days of the day you went home.</i></p>	<p>\$200 plus 10% of the amount the health care professionals in our network have agreed to accept for their services*</p>
<ul style="list-style-type: none"> ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services ○ skilled nursing facility care (100 days for each admission) 	<p>10% of the amount the health care professionals in our network have agreed to accept for their services</p>

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$200 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first \$200 of the cost of your care (\$400 total).
- If three or more people are covered under your plan, together you will pay the first \$400 of the cost of your care. However, the most one family member will pay is \$200.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$200 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using network professionals

If you are the only one covered by your plan, you will pay \$2,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay \$2,500 (\$5,000 total).
- If three or more people are covered under your plan, together you will pay \$5,000. However, no family member will pay more than \$2,500 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay \$4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).
- If three or more people are covered under your plan, together you will pay \$8,000. However, no family member will pay more than \$4,000 toward the limit.

*The following do not count toward the calendar year out-of-pocket maximum:

- your share of the cost of adult routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your benefits
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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Your prescription drug plan

Your Prescription Drug 10-30-50-20% Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay	Tier 4 Copay
Up to a 30-day medication supply at participating pharmacies	\$10	\$30	\$50	20% coinsurance with a \$200 prescription maximum
Up to a 90-day medication supply delivered to your home	\$25	\$75	\$125	20% coinsurance with a \$400 prescription maximum

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum. Please refer to the benefit summary included with your enrollment brochure for the out-of-pocket maximum established for your medical and pharmacy benefit.

Retail pharmacy network

Our network includes more than 56,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

To make sure your pharmacy's in our network, visit anthem.com.

- Log in and click on "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left hand column.
- Click on "Find a Pharmacy."

Choosing a non-network pharmacy means you'll pay the full cost of your drug. Then, you may submit a claim form to be repaid. To access the form, visit anthem.com.

- Log in and select the "Refill a Prescription" link. You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left-hand column, then click on "Coverage & Copayments." The claim form is on this page.

Note about your pharmacy information on the web:

Express Scripts is the company that manages the operations of your drug plan. The first time you're directed to the Express Scripts website, you'll go through a brief registration. The purpose is to set your preferences for communication and privacy. You'll do this only once.

To access your pharmacy information, log on to anthem.com.

Home Delivery Pharmacy

Home delivery is for people who take medications on an ongoing basis. Our preferred Home Delivery Pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Your prescription drug plan (continued)

Getting started with home delivery

Switching is simple. You can order by mail or fax. Your order should arrive within 14 days from the date your order is received.

By mail: Visit anthem.com to get an order form.

- Log in and select “Refill a Prescription.” You will be directed to the Express Scripts website.
- Click on “Fill a New Prescription.”
- Choose the “Print a Prescription Order Form” link. You can print the form and complete it by hand. Or you can fill out a web-based form and print it.
- Mail your completed form, prescription from your doctor for a 90 day supply, and payments to:

Home Delivery Pharmacy
PO Box 66558
St. Louis MO 63166-6558

By fax: Have your doctor fax your prescription and plan ID card information to **800-600-8105**. It must be faxed directly from your doctor’s office. If there is a question about your prescription, the pharmacy will contact your doctor.

Ordering refills

With home delivery, you don’t have to worry about running out of medication. That’s because the pharmacy will let you know when it’s time to order refills. You can easily order by phone, mail or online:

By phone: Have your prescription label and credit card ready. Call **866-281-4279** and select “Automated Refill Order Line” option from the menu. Or press zero at any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

By mail: Fill out an order form you received with a previous order. Affix your label or write the prescription refill number in the space provided. Mail the order form with the proper payment to:

Home Delivery Pharmacy
PO Box 66785
St. Louis MO 63166-6785

Online: Visit anthem.com.

- Log in and select “Refill a Prescription”. You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click “Add Refills to Cart.”
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click “Place My Order.”

Specialty Pharmacy

Accredo, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. Specialty medications are limited up to a 30 day supply regardless of whether they are retail or home delivery. They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn’s Disease
- Growth Hormone

Your prescription drug plan (continued)

- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments.

Accredo CareLogic® programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication and side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. They will also help you manage the side effects of treatment.

Call 888-773-7376 to learn about how CareLogic can help you better manage your health condition.

Ordering specialty drugs

You can place your first order by phone or fax:

By phone: Call **Accredo member services at 800-803-2523**, Monday through Friday, 8 a.m. to 11 p.m. and Saturday 8 a.m. to 5 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your ID card to Accredo at **800-391-9707**, or your doctor can call in your prescription by phone by calling Accredo at **866-759-1557**.

Ordering refills

Online: Visit **anthem.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Chose the drugs you want to refill, and click "Add refills to Cart."
- Review the order, shipping method, payment, medical information and contact information and make changes if needed.
- Click "Place My Order."

Note: For some drugs, you must call to order a refill.

Drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs.

We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit **anthem.com**. Click on "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the Drug List on this page.

If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Your prescription drug plan (continued)

Generic drugs

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of a brand drug – but usually at a lower cost.

Brand and generic drugs have the same active ingredient, strength and dose. And generics must meet the same high standards for safety, quality and purity.

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

Why generics cost less

Developing a new drug is expensive. When a company creates a new drug, it gets a patent for up to 20 years. That means only the company that created it can sell it during that time. Once the patent expires, other companies can make copies of the same drug. These companies avoid the high costs of developing the drug – and that helps lower the price for you.

Talk to your doctor to see if a generic is right for you. Don't switch or stop taking any drugs until you talk to your doctor.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less
- Rules for use with very specific conditions

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

The Drug List also includes this information. To view it, visit anthem.com. click on "Customer Care" in the top-right corner. Select your state, and then click on "Download Forms." You'll find the Drug List on this page.

Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

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