COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HUMAN RESOURCE MANAGEMENT

June 16, 2017

The attached Benefit Summary is being provided to you based on your application for health benefits under the Line of Duty Act (LODA), which are transitioning to the new LODA Health Benefits Plans effective July 1, 2017. Based on that information, you, or the individuals whom you represent, have been enrolled in either the ***LODA Plan – Former LODA Employment*** or ***LODA Plan – Current LODA Employment***, which have the same benefit provisions. This Benefit Summary provides information about the services covered under your new plan. You will also receive a complete Summary Plan Description in a separate mailing. Your new ID cards will also be mailed separately within the next week.

Following are eligibility provisions for the two plans that are summarized in this booklet. Based on these provisions, if you think you should not be in one of these plans, please contact the Department of Human Resource Management by email at LODA@dhrm.virginia.gov.

LODA Plan – Former LODA Employment:
If you are a LODA-eligible retiree, survivor, LTD participant or other LODA participant who does not work for a LODA employer (former employees) and are not eligible for Medicare, or if you are an eligible covered family member based on former employment, you will be covered in this group.

LODA Plan – Current LODA Employment:
If you are a LODA-disabled person who is currently employed by a LODA employer, you and your eligible family members will be covered in this group regardless of Medicare status.

If other LODA-eligible family members should have Medicare as the primary payer for covered health services, they will receive a separate Benefit Summary for ***LODA Plan – Medicare Primary*** that will include Medicare-coordinating information.

Anthem Blue Cross and Blue Shield (BCBS) is the claims administrator for medical, behavioral health and employee assistance program (EAP), outpatient prescription drugs,

vision, and hearing benefits under these plans. Under a separate agreement with Anthem BCBS, Delta Dental of Virginia administers your dental benefit claims.

As with all health plans, these plans do not cover everything. Even more important, payment for services is almost always conditional. That is, payment may be reduced or even denied for a service if you received the service without observing all of the conditions and limits under which the service is covered. Finally, you almost always have to pay for part of the cost of treatment. You are responsible for knowing what is covered and the limits and conditions of coverage. Your Summary Plan Description, which will be sent to you separately, will include more information describing general rules governing benefits, conditions for coverage, plan exclusions, and eligibility. For medical or behavioral health benefits, your out-of-pocket costs will usually be lower if you use an in-network provider since your benefit will be reduced by 25% if you use an out-of-network provider.

If you need additional information regarding covered services or participating providers, contact information and resources are provided on page one of the following Benefit Summary.

LODA HEALTH BENEFITS PLANS

Benefits Summary

for

LODA Plan – Former LODA Employment

LODA Plan – Current LODA Employment

July 1, 2017

Administered by the Department of Human Resource Management
Commonwealth of Virginia

Benefit Summary
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Important Contacts

All Plan Administrators offer language translation by calling Member Services. Anthem and Delta Dental also provide written translation.

Todos los Administradores de Planes ofrecen servicios de traducción. Para recibirlos, debe comunicarse con el Servicio de Atención al Cliente. Anthem y Delta Dental también ofrecen servicios de traducción escrita.

Anthem Blue Cross and Blue Shield - Medical, Behavioral Health, Outpatient Prescription Drugs, Vision, and Hearing
800-552-2682
For the hearing impaired, please contact your state's relay service by dialing 711.

Hours of Operation:
Monday-Friday 8:00 a.m. to 6:00 p.m. ET
Saturday 9:00 a.m. to 1:00 p.m. ET
www.anthem.com/cova

Anthem Behavioral Health and Employee Assistance Program (EAP)
(access to services and authorizations)
844-271-7688

Hours of Operation:
24 hours a day, 7 days a week
www.anthemeap.com
Login: LODA

Prescription Drug Home Delivery
800-355-8279

Hours of Operation:
24 hours a day, 7 days a week

Delta Dental of Virginia - Dental
888-335-8296

Hours of Operation:
Monday-Thursday 8:15 a.m. to 6:00 p.m. ET
Friday 8:15 a.m. to 4:45 p.m. ET
www.deltadentalva.com (Select the Commonwealth of Virginia link)

How to find a Provider
A directory of participating Providers may be accessed online at each Plan Administrator's website.

LODA Plan – Former LODA Employment and *LODA Plan – Current LODA Employment* Summary of Benefits

This chart is an overview of your benefits for covered services. Additional information regarding covered services follows this chart.

What will I pay?
This chart shows what you pay for Deductibles, Copayments, Coinsurance and Out-of-Pocket Expenses for covered services in one Plan Year.

	Single (You Only)	**Plus One (You and One Family Member)**	**Family (You and Two or More Family Members)**
Plan Year Deductible (applies as indicated)	$300	$600	$600
Plan Year Out-Of-Pocket Expense Limit	$1,500	$3,000	$3,000

	You Pay In-network[1] Copayment	**You Pay In-network[1] Coinsurance**
Ambulance Travel	$0	20% after Deductible
Behavioral Health and EAP		
Inpatient treatment		
Facility Services	$300 per Stay	0%
Professional Provider Services	$0	0%
Residential Treatment Program	$300 per Stay	0%
Partial Hospitalization (Day) Program	$125 per Episode of Care	0%
Intensive Outpatient Treatment Program (IOP)	$125 per Episode of Care	0%
Outpatient Treatment Program		
Facility Services	$125 per Episode of Care	0%
Non-Medical professional[2]	$25	0%
Medical professional	$25	
Employee Assistance Program Up to four Visits per issue (per Plan Year)	$0	0%
Dental Services (non-routine Medical)	$0	20% after Deductible
Diabetic Equipment	$0	20% after Deductible
Diabetic Education	$0	0%

[1] Except in an emergency, your medical or behavioral health benefit will be reduced by 25% if you use an out-of-network provider.

[2] Includes independently licensed professionals with a master's or doctoral degree.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance
Diagnostic Tests, Labs and X-rays		
Outpatient Surgery[3]	$0	0%
Outpatient Diagnostic Services Only	$0	20% after Deductible
Outpatient Emergency Room	$0	20% after Deductible
Dialysis Treatments		
Facility Services	$0	0%
Doctor's Office	$0	0%
Doctor's Visits (On an Outpatient basis)		
Primary Care Physicians	$25	0%
Specialty Care Providers	$40	0%
LiveHealth Online	$25	0%
Early Intervention Services	Copayment/Coinsurance determined by service received.	
Emergency Room Visits		
Facility Services	$150 per Visit (waived if admitted to hospital)	0%
Professional Provider Services		
Primary Care Physicians	$25	0%
Specialty Care Providers	$40	0%
Diagnostic Tests, Labs and X-rays	$0	20% after Deductible
Home Health Services 90-Visit Plan Year limit per member	$0	0%
Home Private Duty Nurse's Services	$0	20% after Deductible
Hospice Care Services	$0	0%
Hospital Services		
Inpatient Care		
Facility Services	$300 per Stay	0%
Primary/Specialty Care Physicians	$0	0%
Diagnostic Tests, Labs and X-rays	$0	0%
Outpatient Care (including Observation)		
Facility Services	$125	0%
Professional Provider Services		
Primary Care Physicians	$25	0%
Specialty Care Providers	$40	0%
Diagnostic Tests, Labs and X-rays	$0	20% after Deductible
Maternity		
Professional Provider Services		
Prenatal and Postnatal Care		
Primary Care Physicians	$25	0%
Specialty Care Providers	$40	0%
Delivery		
Primary/Specialty Care Physicians	$0	0%

[1] Except in an emergency, your medical or behavioral health benefit will be reduced by 25% if you use an out-of-network provider.

[3] Diagnostic tests, labs and X-rays are covered under the Outpatient Facility Copayment when billed by a Facility in conjunction with a surgery.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance
Maternity (continued)		
Hospital Services for Delivery Delivery room, anesthesia, nursing care for newborn	$300 per Stay	0%
Diagnostic Tests, Labs and X-rays	$0	20% after Deductible
Medical Equipment (durable), Appliances, Formulas, Prosthetics and Supplies	$0	20% after Deductible
Outpatient Prescription Drugs - Mandatory Generic		
Retail Pharmacy		
Covered drugs per 34-day supply		
First Tier	$15	0%
Second Tier	$30	0%
Third Tier	$45	0%
Fourth Tier (Specialty Drugs)[4]	$55	0%
Home Delivery Services (Mail Order) Covered drugs for up to a 90-day supply		
First Tier	$30	0%
Second Tier	$60	0%
Third Tier	$90	0%
Fourth Tier (Specialty Drugs)[4]	$110	0%
Diabetic Supplies	$0	20%, no Deductible
Shots (Allergy and Therapeutic Injections) At a doctor's office, Emergency room or Outpatient hospital department	$0	20% after Deductible
Skilled Nursing Facility Stays 180-day per Stay limit per member		
Facility Services	$0 per Stay	0%
Primary/Specialty Care Physicians	$0	0%
Surgery		
Inpatient		
Facility Services	$300 per Stay	0%
Primary/Specialty Care Physicians	$0	0%
Diagnostic Tests, Labs and X-rays	$0	0%
Outpatient		
Facility Services	$125 per Visit	0%
Professional Provider Services		
Primary Care Physicians	$25	0%
Specialty Care Providers	$40	0%

[1] Except in an emergency, your medical or behavioral health benefit will be reduced by 25% if you use an out-of-network provider.

[4] Specialty drugs are typically higher cost brand name drugs used to treat chronic and rare conditions.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance
Therapy – Outpatient Services		
Cardiac Rehabilitation Therapy		
Facility Services	$0	0%
Primary/Specialty Care Physicians	$0	0%
Chiropractic, Spinal Manipulations and Other Manual Medical Interventions 30-Visit Plan Year limit per member		
Primary Care Physicians	$25	0%
Specialty Care Providers	$35	0%
Infusion Services (Includes IV or Injected chemotherapy)		
Facility Services	$0	20% after Deductible
Primary/Specialty Care Physicians	$0	20% after Deductible
Home Health Services	$0	20% after Deductible
Infusion Medications		
Outpatient Settings	$0	20% after Deductible
Home Settings	$0	20% after Deductible
Occupational Therapy		
Facility Services	$35	0%
Professional Provider Services		
Primary Care Physicians	$25	0%
Specialty Care Providers	$35	0%
Physical Therapy		
Facility Services	$15	0%
Primary/Specialty Care Physicians	$15	
Radiation Therapy		
Facility Services	$0	0%
Primary/Specialty Care Physicians	$0	0%
Respiratory Therapy		
Facility Services	$0	0%
Primary/Specialty Care Physicians	$0	0%
Speech Therapy		
Facility Services	$35	0%
Professional Provider Services		
Primary Care Physicians	$25	0%
Specialty Care Providers	$35	0%

[1] Except in an emergency, your medical or behavioral health benefit will be reduced by 25% if you use an out-of-network provider.

Summary of Benefits continued	You Pay In-network[1] Copayment	You Pay In-network[1] Coinsurance
Vision Correction After surgery or accident	$0	20% after Deductible
Wellness and Preventive Care Services		
Well Child		
Office Visits at specified intervals		
Primary/Specialty Care Physicians	$0	0%
Immunizations[5]		
Primary/Specialty Care Physicians	$0	0%
Screening Tests	$0	0%
Routine Wellness		
Check-up Visit (one per Plan Year)		
Primary/Specialty Care Physicians	$0	0%
Immunizations[5]		
Primary/Specialty Care Physicians	$0	0%
Routine Lab and X-ray Services	$0	0%
Wellness and Preventive Care Services (one of each per Plan Year)		
Gynecological Exam		
Primary/Specialty Care Physicians	$0	0%
Pap Test	$0	0%
Mammography Screening	$0	0%
Prostate Exam (digital rectal exam)		
Primary/Specialty Care Physicians	$0	0%
Prostate Specific Antigen Test	$0	0%
Colorectal Cancer Screenings	$0	0%

[1] Except in an emergency, your medical or behavioral health benefit will be reduced by 25% if you use an out-of-network provider.

[5] Routine immunizations are only covered in the doctor's office or through the Outpatient pharmacy benefit. Routine immunizations are not covered in an Outpatient hospital Setting.

Summary of Benefits continued

Dental Services – Basic, Primary, Major, and Orthodontic Dental	You Pay In-network Copayment Single (You Only)	You Pay In-network Coinsurance Plus One (You and One Family Member)	Family (You and Two or More Family Members)
Diagnostic and Preventive Services	$0	0%, no Deductible	
Plan Year Deductible (Primary / Major only)	$50	$100	$150
The most Your Health Plan pays per person per Plan Year is $2,000			
Primary Dental Care	$0	20% after Deductible	
Major Dental Care	$0	50% after Deductible	
Orthodontic Services ($2,000 lifetime maximum per person)	$0	50% no Deductible	

Routine Vision – Blue View Vision Network

These benefits are available once per Plan Year.

	You Pay In-network
Routine eye exam	$40 Copayment
Eyeglass frames	20% discount after plan pays first $100
Eyeglass lenses	
- Single vision lenses	$20 Copayment
- Bifocal lenses	$20 Copayment
- Trifocal lenses	$20 Copayment
OR	
Contact lenses - Conventional	15% discount after plan pays $100
- Disposable - Non-elective	Balance after $100 allowance Balance after plan pays $250
Contact lens fit and follow-up (standard)	Up to $55
Contact lens fit and follow-up (premium)	10% off retail price

Routine Hearing

You pay the remaining cost for hearing aid services and supplies after Your Health Plan's Reimbursement.

	You Pay In-network
Routine hearing test (once per Plan Year)	$40 Copayment
Purchase of hearing aids and other related hearing aid services and supplies except disposable hearing aids. (Available every 48 months. Your Health Plan pays a maximum of $1,200 during the 48 months.)	Balance after plan pays $1,200

FACILITY SERVICES

HOSPITAL SERVICES

The charges made by a hospital for use of its facilities and services are eligible for Reimbursement under many circumstances.

Services Which Are Eligible for Reimbursement

1) Emergency room services leading directly to admission or which are rendered to a patient who dies before being admitted. In an Emergency, go to the nearest appropriate Provider or Medical Facility. For Medical admissions, call Anthem member services to obtain Hospital Admission Review. For Behavioral Health admissions, contact Anthem Behavioral Health.

2) Bed and board in a semi-private room, including general nursing services and special diets. A bed in an intensive care unit is eligible for Reimbursement for critically ill patients. Your Health Plan covers the charge for a private room if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your Medical condition; or if the hospital only has private rooms. Otherwise, you have coverage for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.

3) Customary ancillary services for Inpatient Stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, diagnostic tests and therapy services, professional ambulance services for transportation between local hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered maternity service.

4) If complications arise during a newborn’s confinement or if the newborn does not go home with the mother, a Hospital Admission Review would be required for the newborn. Eligibility criteria must be met for the newborn to receive benefits. Newborns must be added to the health plan within 60 days of the date of birth.

5) Detoxification and Residential Treatment for Behavioral Health services. These services are available on the same basis as Inpatient services.

6) Outpatient hospital services including Observation services, Pre-Admission Testing and other diagnostic tests, therapy services, Shots, prescription medications received during treatment, surgical services, mammography, routine colonoscopy screening and Intensive Outpatient Treatment and Partial Day Hospitalization for Behavioral Health.

7) Dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

8) The cost of blood, blood plasma, blood derivatives, storage of blood by a hospital, or professional donor fees.

SKILLED NURSING FACILITY SERVICES

Services Which Are Eligible for Reimbursement

1) Your Health Plan will cover your semi-private room in a network Skilled Nursing Facility. The room charge includes your meals, any special diets, and general nursing services. You are also entitled to receive the same types of ancillary services which are available to a hospital Inpatient.

Your Health Plan will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your Medical condition. Otherwise, your Inpatient benefits will cover the Skilled Nursing Facility's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your Copayment and Coinsurance (if any).

HOME HEALTH SERVICES

Services Which Are Eligible for Reimbursement

1) Professional Medical services.

2) Periodic skilled nursing care for needs that can only be met by a Licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) under the supervision of an R.N.

3) Therapy services.

4) Medical social services provided by a licensed clinical social worker or social services assistant under the guidance of a licensed clinical social worker.

5) Services eligible for coverage by a home health aide for personal care provided the member has a skilled need and the services are under the supervision of an R.N.

6) Nutritional guidance, but limited to individual consultation by an R.N. or qualified dietician.

7) Diagnostic tests, non-covered therapy services, and similar services which would be covered if you were an Inpatient in a hospital. These services are also covered when received in your Provider's office or the Outpatient department of a hospital, but the services must be arranged through the network home health care agency.

8) Ambulance services if prearranged by your physician and authorized by the Plan Administrator if, because of your Medical condition, you cannot ride safely in a car when you go to your Provider's office or to the Outpatient department of the hospital. Ambulance services will be covered if your condition suddenly becomes worse and you must go to a local hospital's Emergency room.

9) Supplies normally used in a hospital for an Inpatient, but these supplies must be dispensed by the network home health care agency.

10) Administration of drugs prescribed by your Provider.

PROFESSIONAL SERVICES

MEDICAL, SURGICAL, AND BEHAVIORAL HEALTH SERVICES

This section explains which Medical, surgical, and Behavioral Health services from health professionals may be eligible for Reimbursement. In general, the professional services of authorized Providers are eligible for Reimbursement if they are Medically Necessary and rendered within the scope of the Provider's license.

Services Which Are Eligible for Reimbursement

1) Inpatient Medical, surgical, and Behavioral Health services. These services are specifically included:

   - surgical services;
   - reconstructive surgery to restore a body function, correct congenital or developmental deformity which causes functional impairment, or relieve pain;
   - operative procedures for sterilization or to reverse a sterile condition;
   - multiple surgeries;
   - assistant surgeon's services;
   - maternity services rendered during an Inpatient Stay:
     - routine delivery services (cesarean birth is a surgical service);
     - anesthesia services to provide complete or partial loss of sensation before delivery;
     - services for complications of pregnancy;
     - services for miscarriage; and
     - services for the care of a newborn child if the child is enrolled as an eligible dependent for the time the services are rendered such as:
       - initial examination of a newborn and circumcision of a covered male dependent
       - hospital services for non-routine nursery care for the newborn should complications arise that require the newborn to be admitted
   - anesthesia services rendered by a second physician;
   - Medical and Behavioral Health Visits by a Provider, including:
     - intensive Medical services (when your Medical condition requires a Provider's constant attendance and treatment for a prolonged period of time);
     - concurrent care (treatment you receive from a Provider other than the operating surgeon for a Medical condition separate from the condition for which you required surgery);
     - Behavioral Health evaluative and concurrent services; and
     - consultative services from a Provider other than the attending Provider.

2) Outpatient Medical, surgical, and Behavioral Health services, including:

   - office Visits;
   - surgical services;
   - LiveHealth Online;
   - Telemedicine;
   - maternity services including Visits to a Provider for routine pre- and postnatal care;
   - delivery of a newborn at home by a Provider;
   - anesthesia services;

- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies;
- Medical services to diagnose or treat your illness or injury;
- diagnostic tests, labs and x-rays;
- therapy services;
- Shots;
- diabetes Outpatient self-management training and education performed in person, including Medical nutrition therapy when provided by a certified, licensed, or registered health care professional. These services are only covered when billed by a Medical Provider or the Outpatient department of a hospital. Diabetic education is covered at no cost to you;
- a Medical or surgical service if performed by a Provider's employee who is licensed to perform the service; and
- prescription medications that require administration by a health professional including contraceptive devices and injections.

3) Treatment of morbid obesity

Your Health Plan may cover treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting Medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

As used above, body mass index equals weight in kilograms divided by height in meters squared.

Getting started:

- Your bariatric surgeon must contact Anthem to request a Health Services Review for your surgery.

<u>Post weight loss procedures</u>
Your Health Plan may also cover some services (such as abdominoplasties, panniculectomies, and lipectomies) to correct deformity after a previous therapeutic process involving gastric bypass surgery, other bariatric surgery procedures, or other methods of weight loss.

In order to be covered, a service must be Medically Necessary. Before rendering any of these services, your Provider should contact the Plan Administrator and request a Health Services Review. Ultimately, it is your responsibility to ensure that the service is authorized for Medical Necessity.

If a Health Services Review is not obtained and the services are retrospectively denied, you are responsible for payment of non-covered service(s).

BEHAVIORAL HEALTH SERVICES AND EMPLOYEE ASSISTANCE PROGRAM (EAP)

Services Which Are Eligible for Reimbursement

Behavioral Health Services

1) Eligible Behavioral Health services are covered if Medically Necessary. Services for alcohol and substance abuse may be reimbursable when rendered in an Outpatient Setting such as an Intensive Outpatient Treatment Program.

2) Partial Day Hospitalization when rendered in an Outpatient Setting.

3) Detoxification may be reimbursable when rendered in an Inpatient Setting.

4) Residential Treatment may be reimbursable when rendered in an Inpatient Setting. Services provided for Residential Treatment include but are not limited to the following:

    - multi-disciplinary evaluation;
    - medication management;
    - individual, family and group therapy;
    - parental guidance; and
    - substance abuse education/counseling.

5) Residential Treatment Centers must include room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability.

6) Intensive Outpatient Treatment
   Intensive Outpatient Programs (IOP) must:

    - meet at least three times per week;
    - provide a minimum of three (3) hours of treatment per session; and
    - be supervised by a licensed mental health professional.

7) Telemedicine

8) Certain treatments associated with autism spectrum disorder (ASD) for dependents from age 2 through age 10. Coverage for ASD includes but is not limited to the following:

    - diagnosis and treatment of ASD;
    - pharmacy care;
    - psychiatric care;
    - psychological care;
    - therapeutic care; and
    - Applied Behavior Analysis (ABA).

Employee Assistance Program (EAP)

1) The Employee Assistance Program (EAP) is a free, voluntary, confidential service to help you, covered dependents and members of your household deal with personal challenges that can be addressed through short-term counseling.

2) The EAP provides up to four counseling sessions per issue per Plan Year free of charge for you, covered dependents and members of your household. Access to care starts with a phone call to Anthem EAP at **844-271-7688**. Counselors are available to take your call 24 hours a day, seven days a week, to help you address a variety of issues including:

   - relationship or family issues
   - depression and anxiety
   - stress management
   - work issues
   - alcohol or drug abuse
   - daily life challenges

   After assessing your situation, a counselor will recommend whether your care should be provided through the EAP and/or referred to Behavioral Health.

   The EAP can help you locate child and adult care resources. You can also call the EAP for guidance on a number of legal and financial issues, including divorce, domestic violence, estate planning and family budgeting. If you need additional legal or financial assistance, the EAP counselor will refer you to a carefully screened attorney or financial counselor in your community.

3) All services through Anthem EAP are voluntary and confidential in accordance with state and federal laws. Anthem EAP will not disclose information to anyone without your explicit written authorization, except within federal and state guidelines for release of confidential information.

CHIROPRACTIC, SPINAL MANIPULATION AND OTHER MANUAL MEDICAL INTERVENTION SERVICES

Services Which Are Eligible for Reimbursement

Spinal manipulations and other manual Medical interventions and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations are eligible for Reimbursement. These services are most commonly performed by a chiropractor, general practitioner, physical therapist or osteopath.

WELLNESS AND PREVENTIVE CARE SERVICES

Services Which Are Eligible for Reimbursement

Child Wellness and Preventive Care

The following wellness and preventive care screening services are covered:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cholesterol and lipid level screening
- Developmental and behavioral assessments
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- Newborn screenings
- Oral health assessment
- Pelvic exam and Pap test, including screening for cervical cancer
- Screening and counseling for obesity
- Screening for depression
- Screening for lead exposure
- Screening for sexually transmitted infections
- Vision screenings

The following wellness and preventive care immunizations are covered:

- Diphtheria, Tetanus, Pertussis (DTaP)
- Haemophilus Influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (flu)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

The following immunization schedule is recommended for children from birth through 6 years old by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention in partnership with the American Academy of Family Physicians and the American Academy of Pediatrics:

- Birth
- 3-5 days
- 2-4 weeks
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years
- 5 years
- 6 years

Follow your Pediatrician's recommendation for well child and immunization Visits.

The following generic prescription strength over-the-counter (OTC) products are covered, and require a prescription from a Provider:

- Iron supplements for children 6-12 months
- Fluoride supplements for children from birth through 6 years old

Adult Wellness and Preventive Care

The following wellness and preventive care screening and services are covered:

- Annual wellness check-up
- Aortic aneurysm screening (men)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breastfeeding support, supplies and counseling
- Cholesterol and lipid level screening
- Colorectal cancer screening, including
  - one fecal occult blood test; and
  - one flexible sigmoidoscopy, or colonoscopy or double contrast barium enema
- Contraceptive counseling and sterilization procedures
- Diabetes screening
- Eye chart vision screening
- Generic, single source brand and multi-source brand FDA-approved contraceptives and FDA-approved women's over-the-counter (OTC) contraceptives (female condoms, spermicides) all requiring a prescription from a Provider
- Prescription medications, such as Tamoxifen or Raloxifene, for women who are at increased risk for breast cancer as recommended by the United States Preventive Services Task Force (USPSTF-B recommendation). A prescription from a Provider and prior authorization are required.
- Gynecological examination
- Hearing screening
- Height, weight and BMI
- Mammography screening
- Pap test
- Prostate exam (digital rectal exam)
- Prostate specific antigen test (PSA)
- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for sexually transmitted infections - including human immunodeficiency virus (HIV)
- Screening for depression
- Screening for gestational diabetes for women 24 to 28 weeks pregnant, and at high risk of developing gestational diabetes
- Screenings during pregnancy
  - including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV
- Testing for human papillomavirus (HPV)

The following wellness and preventive intervention services (includes counseling and education) are covered:

- Screening and counseling for obesity
- Genetic counseling for women with a family history of breast and/or ovarian cancer
- Behavioral counseling to promote a healthy diet
- Counseling related to aspirin use, folic acid and iron, for the prevention of cardiovascular disease
- Screening and behavioral counseling related to tobacco use
- Screening and behavioral counseling related to alcohol misuse

The following generic prescription strength over-the-counter (OTC) products are covered, and require a prescription from a Provider:

- Aspirin (81mg and 325mg) for men between ages 45-79 and women between ages 55-79
- Low-dose aspirin (81mg) for pregnant women who are at increased risk of preeclampsia
- Bowel Preps between ages 49-76 (two script limit per 365 days)
- Folic acid (.4mg-.8mg) for women through age 55
- Vitamin D (vitamin D2 or D3 containing 1,000 IU or less per dosage form) for women 65 and over

The following wellness and preventive immunizations are covered:

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (flu)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Tetanus, Diphtheria, Pertussis (Tdap)
- Varicella (chicken pox)
- Zostavax (shingles)

The following FDA-approved smoking cessation prescription drugs and certain generic over-the-counter (OTC) nicotine replacement products are covered, and require a prescription from a Provider:

- Chantix
- buproban 150mg
- burpropion SR 150mg (generic Zyban)
- Nicotine gum (except brand Nicorrette)
- Nicotine lozenges (except brand Commit)
- Nicotine patch (except brands Habitrol & Nicoderm)

THERAPY SERVICES

Services Which Are Eligible for Reimbursement

(Chiropractic, spinal manipulation and other manual medical intervention services have a plan year visit limit—see page 13 and the Benefit Summary chart.)

1) Cardiac rehabilitation, which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

2) Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents.

3) Infusion therapy (IV therapy), which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

4) Occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

5) Physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

6) Radiation therapy, including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

7) Respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

8) Speech therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior Medical treatment.

EARLY INTERVENTION SERVICES

Services Which Are Eligible for Reimbursement

Early intervention services are for covered dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (DBHDS) as eligible for services under Part C of the Individuals with Disabilities Education Act (IDEA). You are responsible for contacting your local DBHDS agency to initiate certification.

These services consist of:

- assistive technology services and devices (for example, hearing aids, glasses and durable Medical Equipment);
- occupational therapy;
- physical therapy; and
- speech and language therapy.

HOSPICE CARE SERVICES

Services Which Are Eligible for Reimbursement

1) Hospice care services are available if you are diagnosed with a terminal illness with a life expectancy of six months or fewer.

2) Hospice care services include a program of home and Inpatient care provided directly by or under the direction of a licensed hospice.

3) Hospice care programs include palliative care and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team.

OTHER COVERED SERVICES

Services Which Are Eligible for Reimbursement

1) Professional ambulance services to or from the nearest Facility or Provider adequate to treat your condition. Air ambulance services are also covered when precertified or in cases of threatened loss of life. In determining whether any ambulance services will be precertified, the Plan Administrator will take into account whether appropriate, cost-effective care is being provided at the Facility where the Covered Person is located.

2) Medical supplies are covered if they are prescribed by a covered Provider. Examples of Medical supplies are oxygen and equipment (respirators). Some Medical supplies require Health Services Review. Contact Anthem Member Services at **800-552-2682.**

3) The cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for Activities of Daily Living:

   - arm braces, back braces and neck braces;
   - artificial limbs, including accessories;
   - breast prostheses;
   - catheters and related supplies;
   - head halters;
   - leg braces, including attached or built-up shoes attached to the leg brace;
   - orthopedic braces;
   - orthotics, other than foot orthotics;
   - splints; and
   - wigs.

4) The rental (or purchase if that would be less expensive) of Medical Equipment (durable) when prescribed by your doctor requires Health Services Review. Contact Anthem Member Services at **800-552-2682** for assistance with Health Services Review.

   Also covered are maintenance and necessary repairs of Medical Equipment (durable) except when damage is due to neglect. Network Medical Equipment (durable) Providers are shown in the Anthem Commonwealth of Virginia and The Local Choice Medical Provider Directory under Ancillaries, Durable Medical Equipment. If you obtain equipment from a non-network Medical Equipment (durable) Provider, you will still have coverage. However, in addition to your Deductible and Coinsurance, the non-network Provider may bill you for the difference between the Allowable Charge and the Provider's charge (Balance Bill).

   Coverage includes equipment such as:

   - crutches;
   - hospital-type beds;
   - nebulizers;
   - traction equipment;
   - walkers; and
   - wheelchairs.

In addition, rental of Medical Equipment (durable) will be provided for a limited time for a condition for which you received covered services before your coverage ended. The time will be the shorter of when you become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time you were enrolled under Your Health Plan.

5) Special Medical formulas which are the primary source of nutrition for Covered Persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

6) Covered diabetic equipment includes:

   - insulin pumps and associated supplies;
   - lancet devices; and
   - calibrator solution.

7) Home private duty nursing services when the medically skilled services are provided by a Licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home and the nurse is not a relative or member of your family. Your doctor must certify to Anthem that private duty nursing services are Medically Necessary for your condition, and not merely custodial in nature.

8) The following prescribed eyeglasses or contact lenses only when required as a result of surgery or for treatment of accidental injury:

   a. eyeglasses or contact lenses which replace human lenses lost as the result of intra-ocular surgery or accidental injury to the eye;
   b. "Pinhole" glasses used after surgery for a detached retina; or
   c. lenses used instead of surgery, such as:
      - contact lenses for the treatment of infantile glaucoma;
      - corneal or sceleral lenses in connection with keratoconus;
      - sceleral lenses to retain moisture when normal tearing is not possible or is not adequate; or
      - corneal or sceleral lenses to reduce a corneal irregularity (other than astigmatism).

   A maximum of one set of eyeglasses or one set of contact lenses will be covered for your original prescription or for any change in your original prescription. Examination and replacement for a prescription change are covered only when the change is due to the condition for which you needed the original prescription.

OUTPATIENT PRESCRIPTION DRUGS
(Mandatory Generic Program)

Services Which Are Eligible for Reimbursement

1) The drugs must:

   - by federal or state law, require a prescription order to be dispensed;
   - be approved for general use by the U. S. Food and Drug Administration (FDA);
   - be prescribed by a Provider licensed to do so;
   - be furnished and billed by a pharmacy for Outpatient use; and
   - be Medically Necessary.

2) Outpatient Prescription Drugs received through a retail pharmacy or Anthem's Home Delivery or Specialty Pharmacy Service (provided through Express Scripts Incorporated and Accredo Specialty Pharmacy).

3) Outpatient Prescription Drugs and devices approved by the FDA, including contraceptives and certain prescription smoking cessation drugs. Contact Anthem Member Services for detailed coverage information.

4) The following items for the treatment of diabetes:

   - blood glucose meters;
   - blood glucose test strips;
   - hypodermic needles and syringes;
   - insulin; and
   - lancets.

Anthem's Home Delivery Pharmacy Service

You may also purchase covered Maintenance Medications through the mail from Anthem's Home Delivery Pharmacy network, and your prescription will be delivered directly to your home. To receive your prescription by mail, follow these steps:

You can place your first order by phone or online at **www.anthem.com.**

By phone: Call **800-355-8279**. A representative will help you with your order. Have your prescription, doctor's name, phone number, drug name and strength, and credit card handy when you call.

Online: Login to **www.anthem.com** and select Pharmacy under the Benefits tab. Follow the steps under Pharmacy Self Service to request a new prescription or refill a current prescription.

You will receive your prescription drugs via first class mail or UPS approximately 14 days from the date you sent your order.

Accredo Specialty Pharmacy Service

Accredo Specialty Pharmacy provides you with personal counseling from nurses, registered pharmacists and patient care representatives who are trained in specialty medications. Specialty medications include drugs such as Procrit® to treat anemia, Copaxone® for multiple sclerosis and Enbrel® or Remicade® for rheumatoid arthritis and many other medications. The program includes 24-hour access to an Accredo Specialty Pharmacy pharmacist and free supplies needed to administer your medicine, such as needles and syringes.

Specialty Drugs are those covered drugs that typically have a higher cost and one or more of the following characteristics:

- complex therapy for complex disease;
- specialized patient training and coordination of care (services, supplies, or devices);
- required prior to therapy initiation and/or during therapy;
- unique patient compliance and safety monitoring requirements;
- unique requirements for handling, shipping and storage; and
- potential for significant waste due to the high cost of the drug.

Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug. Some examples of the disease categories currently in Accredo Specialty Pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.

In addition, a follow-on biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.

Call toll-free **877-886-1705** to order your specialty medication. Or if you prefer, your Provider may call the Accredo Specialty Pharmacy directly at **800-987-4904**. More information is available at **www.anthem.com/cova.**

DENTAL SERVICES

Administered by Delta Dental of Virginia

Services Which Are Eligible for Reimbursement

Diagnostic and Preventive Care

Your Health Plan provides coverage for you to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and to try and prevent cavities and serious Dental problems. The following services are generally covered, but in some specific situations certain Exclusions and limitations apply. Covered services include:

- two routine oral evaluations per Plan Year;
- two Dental prophylaxes (cleanings) per Plan Year, including scaling and polishing of teeth;
- Dental x-rays (except x-rays needed to fit braces);
- two sets of bitewing x-rays (two or more films) per Plan Year (vertical bitewings are considered a full mouth series);
- one complete full mouth x-ray series, or a panorex every 36 months (the 36-month count starts the month in which you receive the x-ray series or panorex);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- two pulp vitality tests per tooth (to see if a tooth is still alive) every 12 months (the 12-month count starts the month in which you receive the pulp vitality test);
- care for a toothache (palliative Emergency care);
- two topical fluoride applications per Plan Year only to Covered Persons under age 19;
- Dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to Covered Persons under age 19;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders; and
- occlusal night guards for demonstrated tooth wear due to bruxism; or occlusal orthotic device for treatment of temporomandibular joint dysfunction (TMJ). Services are limited to once in 36 months.

Members have access to the Delta Dental PPO or Premier networks. Should you decide to receive Dental care from a dentist who is not a member of the Delta Dental PPO or Premier networks, you will still receive benefits from your Dental plan, but your share of the cost will likely be higher than if you received care from a network dentist. Also:

- You may have to file any claims yourself.
- Payment will be made directly to you unless your dentist agrees to accept payment from Delta Dental.
- You must pay the applicable Coinsurance and the difference between the non-network dentists' charges and Delta Dental's payment for covered benefits.

Primary Dental Care

Covered services include:

- fillings (amalgam or composite resin materials);
- pin retention;
- simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- root canal therapy (endodontics);
- care for abscesses in the mouth (excision and drainage);
- repair of broken removable dentures;
- surgical preparation of ridges for dentures;
- re-cementing existing crowns, inlays and bridges (once every 12 months);
- removing infected parts of the gum (gingivectomy and gingivoplasty);
- scaling and root planing of the teeth;
- stainless steel crowns for primary teeth only;
- sedative fillings;
- therapeutic pulpotomy;
- periodontal evaluation (not in addition to periodic evaluations);
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts to replace lost or unhealthy gum tissue;
- bone graft (only around natural teeth);
- guided tissue regeneration;
- general anesthesia in connection with a covered surgical Dental service when three or more simple extractions are performed (not covered for deciduous teeth);
- crown lengthening when bone is removed and at least six weeks are allowed for healing;
- hemisection and root amputations;
- apicoectomies;
- intravenous conscious sedation when in conjunction with a surgical procedure;
- full mouth debridement (once per lifetime);
- core build ups (once per tooth every 5 years);
- periodontal maintenance (limited to two per Plan Year);
- restorative (silver and tooth-colored fillings, primary teeth only stainless steel crowns, and other restorative services) retreatment limited to once per surface in a 2 year period; and
- trips by the dentist to your home if you need any of the services you see listed here.

Major Dental Care

Covered services include:

- inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- onlays (limited to the benefit for a metallic restoration);
- crowns and crown repair (once per tooth every 5 years);
- labial veneers involving the incisal edge of anterior teeth, porcelain laminate (laboratory processed);
- Dental implants (once per tooth every 5 years);
- dentures (full and partial), and denture adjustments and relining; and
- fixed bridges and repair.

Orthodontic Benefits

Covered services include:

- orthodontic appliances (installing only, no replacement or repair);
- services needed to diagnose the problem, including x-rays, study model and diagnostic casts;
- tooth guidance and harmful habit appliances;
- interceptive treatment;
- surgical access of unerupted teeth when performed for orthodontic purposes; and
- orthodontic evaluations when no treatment is initiated.

Transition of Care and Limitations

1) If you transfer from the care of one dentist to another during a course of treatment, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

2) If more than one dentist renders services for one procedure, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

3) If Dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Delta Dental before services are provided.

4) By submitting a predetermination plan, you and your dentist will be informed of the total costs associated with the procedure(s), the exact amounts that will be covered by Your Health Plan, and the portion of the charges for which you will be responsible. A predetermination plan is not required by Your Health Plan but recommended when extensive Dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.

DENTAL SERVICES – NON-ROUTINE MEDICAL

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Non-routine Medical benefits for oral surgery:

   - surgical removal of impacted teeth;
   - maxillary or mandibular frenectomy when not related to a Dental procedure;
   - alveolectomy when related to tooth extraction;
   - orthognathic surgery that is required because of a Medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
   - surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures;
   - the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
   - Dental services and Dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
   - Dental services to prepare the mouth for radiation therapy to treat head and neck cancer.

2) Non-routine Medical benefits for accidental injury:

   - Medically Necessary Dental services when required to diagnose and treat an accidental injury to the teeth if the accident occurs while you are covered under Your Health Plan; and
   - the repair of Dental appliances damaged as a result of accidental injury to the jaw, mouth or face.

ROUTINE VISION AND HEARING

Administered by Anthem Blue Cross and Blue Shield (Blue View Vision network)

(See Benefit Summary Chart for limitations.)

Routine Vision

The Blue View Vision network is for routine eye care only and is a separate network from the Anthem Medical network. Non-routine vision care is covered under your Anthem Medical benefits.

<u>Services Which Are Eligible for Reimbursement</u>

1) Routine vision examination.
2) Frames and eyeglass lenses or contact lenses to correct vision.

Routine Hearing

<u>Services Which Are Eligible for Reimbursement</u>

1) Routine hearing examination.
2) Hearing aids and other related hearing aid services and supplies except disposable hearing aids. Examples of covered supplies necessary for the use of the hearing aid include ear molds, ear buds (not required for all hearing aids), filter and batteries.

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