Virginia Mid-Size Group benefit changes

Effective at renewal on or after January 1, 2021

Anthem. And Its Affiliate HealthKeepers, Inc.

Thank you once again for offering your employees Anthem Blue Cross Blue Shield health care coverage. We would like to take this opportunity to let you know about some important changes affecting your plan. The following changes apply to Anthem and Anthem HealthKeepers plans. Ask your Sales Representative for full details on these changes.

Product changes

New coverage for all plans:

- LiveHealth Online (LHO) is expanding covered services to include sleep medicine services. Coverage will be for virtual consultations and home sleep studies. Member cost share will be the same as a specialist office visit.

Changes based on plan design: (refer to chart below for specific plans impacted)

- Introducing Enhanced Personal Health Care (EPHC) provider copay on most copay based plans. This innovative payment model holds providers accountable for cost and quality outcomes through value-based incentives. EPHC provider copays are typically $10 less than other PCPs, with a minimum of $10 copay.
- Outpatient facility Lab and X-ray diagnostic cost share on copay plans will change from the Outpatient facility copay to Specialist copay. This lower copay is more aligned to the average cost of these services.
- Advanced Diagnostic Imaging copay will apply per test. Previously a copay may have covered more than one test if administered on the same date of service.
- Office-based Physical, Occupational and Speech therapies will change from Ded/Coins to PCP Copay for each service on Copay/Ded/Coinsurance plans.
- Outpatient surgery at a facility copay will be $300; some copay plans will see an increase of $50 to $100.
- Global Maternity copay will be $300; some copay plans will see an increase of $50 to $100.
- LHO copay will be $10 for all plans with PCP copays of $10 to $30. For plans with PCP $35 copay, LHO copay will be $15.

Medical benefit changes	**Plans impacted** (Anthem and Anthem HealthKeepers)
Outpatient facility Lab and X-ray diagnostic copay change to Specialist copay	15/20%/3500, 15/20%/4000, 20/20%/4000, 20/20%/4500, 25/20%/4500 and 25/30%/5000
EPHC, LHO copays and Advanced Diagnostic Imaging copay change to per test	15/20%/3500, 15/20%/4000, 20/20%/4000, 20/20%/4500, 25/20%/4500 and 25/30%/5000
EPHC, LHO copays and Physical, Occupational and Speech therapy office based services change to PCP copay	25 500/20%/4000, 25 500/30%/4500, 30 1000/20%/4500, 30 1000/30%/5000, 30 1500/20%/5250, 30 2000/20%/5500, 30 2000/30%/6000, 30 2500/20%/6500, 30 3000/20%/7000, 30 4000/20%/7350, 30 4000/30%/7350, 30 5000/20%7900, 30 5000/30%/8200, 35 6000/20%/8150 and 35 6000/30%/8550
Outpatient facility surgery copay and Global Maternity copay increase	Increase by $100: 15/20%/3500 Increase by $50: 15/20%/4000, Select 2000/0%/6000
EPHC copay	Elements Choice HSA 4500/40%/6900

- HSA pharmacy plan design is changing for a few plans that have a 20% coinsurance. In the past, the pharmacy coverage was the same as medical – Ded/20%. In recognition of market preference for pharmacy copays, the following plans will change pharmacy coverage to Ded/$10/$40/$70/20% to $300 at renewal.

2020 plan	2021 revisions
HSA 1500NE/20%/3950 Rx Ded/20%	HSA 2000NE/20%/4250 Rx Ded/$10/40/70/20% to $300
HSA 2800/20%/5000 Rx Ded/20%	HSA 2800/20%/5000 Rx Ded/$10/40/70/20% to $300
HSA 3000/20%/5000 Rx Ded/20%	HSA 3000/20%/5500 Rx Ded/$10/40/70/20% to $300

- Anthem is introducing plans that offer lower member costs when using participating independent ambulatory surgical and radiology centers. These centers offer an alternative to higher cost care facility settings and will benefit all members, regardless of plan design. Some plans will have cost shares change from Ded/Coinsurance to Copay as shown below. Participating independent surgical and radiology centers will be identified anthem.com in the "Find Care" tool as *Site of Service* providers.

<table>
<tr><td rowspan="2">Plan (Anthem, Anthem HealthKeepers)</td><td colspan="2">O/P Hospital Surgery</td><td colspan="2">Ambulatory Surgical Center (new)</td><td>O/P Hospital ADI</td><td>Ambulatory Radiology Center (new)</td></tr>
<tr><td>Facility</td><td>Physician</td><td>Facility</td><td>Physician</td><td colspan="2">Advanced Diagnostic Imaging</td></tr>
<tr><td>15/20%/3500, 15/20%/4000</td><td>$300</td><td>$35</td><td rowspan="2">$150</td><td rowspan="2">CIF*</td><td>$200</td><td rowspan="2">$150</td></tr>
<tr><td>20/20%/4000</td><td>$300</td><td>$40</td><td>$250</td></tr>
<tr><td>20/20%/4500</td><td>$350</td><td>$40</td><td rowspan="3">$200</td><td rowspan="3">CIF*</td><td rowspan="3">$350</td><td>$150</td></tr>
<tr><td>25/20%/4500</td><td>$350</td><td>$40</td><td rowspan="2">$200</td></tr>
<tr><td>25/30%/5000</td><td>$350</td><td>$50</td></tr>
<tr><td>25 500/20%/4000, 25 500/30%/4500
30 1000/20%/4500, 30 1000/30%/5000
30 1500/20%/5250</td><td colspan="2">Ded/20% or Ded/30%</td><td>$300</td><td>$50</td><td colspan="2">No change</td></tr>
<tr><td>30 2000/20%/5500, 30 2000/30%/6000
30 2500/20%/6500, 30 3000/20%/7000</td><td colspan="2">Ded/20% or Ded/30%</td><td>$350</td><td>$50</td><td colspan="2">No change</td></tr>
<tr><td>30 4000/20%/7350, 30 4000/30%/7350
30 5000/20%7900, 30 5000/30%/8200</td><td colspan="2">Ded/20% or Ded/30%</td><td>$400</td><td>$50</td><td colspan="2">No change</td></tr>
<tr><td>35 6000/20%/8150, 35 6000/30%/8550</td><td colspan="2">Ded/20% or Ded/30%</td><td>$400</td><td>$60</td><td colspan="2">No change</td></tr>
</table>

*CIF-Covered in Full

- One HSA plan will increase the deductible and in-network out-of-pocket.

2020 Plan (Anthem, Anthem HealthKeepers)	2020 single/family	2021 single/family	2021 Plan (Anthem, Anthem HealthKeepers)
HSA 1500NE/20%/3950	$1500/3000 Ded $3950/$7900	$2000/4000 Ded $4250/$8500	HSA 2000NE/20%/4250

- In-network out-of-pocket maximum is increasing on some plans. As a result of the in-network change, the out-of-network out-of-pocket will also increase. Plan names will be adjusted to reflect the new INN out-of-pocket value.

2021 In-network out-of-pocket changes			
2020 Plan (Anthem, Anthem HealthKeepers)	2020 single/family	2021 single/family	2021 Plan (Anthem, Anthem HealthKeepers)
30 5000/30%/7900	$7900/$15800	$8200/$16400	30 5000/30%/8200
35 6000/30%/7900	$7900/$15800	$8550/$17100	35 6000/30%/8550
2000/50%/7350	$7350/$14700	$7500/$15000	2000/50%/7500
HSA 2800/0%/4000	$4000/$8000	$4500/$9000	HSA 2800/0%/4500
HSA 3000/0%/4000	$4000/$8000	$4500/$9000	HSA 3000/0%/4500
HSA 3000/20%/5000	$5000/$10000	$5500/$11000	HSA 3000/20%/5500
HSA 5000/0%/6750	$6750/$13500	$6900/$13800	HSA 5000/0%/6900
Elements Choice HSA 4500/40%/6750	$6750/$13500	$6900/$13800	Elements Choice HSA 4500/40%/6900

Pharmacy changes

With pharmacy benefits being the most utilized health care benefit, Anthem is rolling out pharmacy products and programs that allow us to best manage cost while still maintaining member flexibility and a strong member experience. In addition, some pharmacy cost shares have changed to keep up with the rising costs of pharmacy trend.

***New* Standard Network with R90, Opt-out Home Delivery**

- The Standard network is comprised of approximately 58,000 pharmacies nationwide, anchored with one major pharmacy chain; CVS and other pharmacies such as Walmart, Costco, Kroger, and Rite Aid as well as independent pharmacies. The Standard network excludes Walgreens and Walgreens-affiliated pharmacies, which drives significant savings for clients.

- Home Delivery is an important component of pharmacy coverage. We are changing our Home Delivery program from Optional to Opt-out Home Delivery (HD). This benefit provides members the ability to opt-out of "mandatory mail" plan design. If members do not opt-out, they must receive their 90-day maintenance medication through home delivery powered by IngenioRx Mail or a CVS retail pharmacy where they can also get a 90-day supply and pay the same cost share as home delivery. Members will receive a reminder letter for new prescriptions to designate the preferred method to receive their medications.

Other pharmacy changes

- Due to increasing pharmacy trends, especially for higher cost multi-source brand name prescriptions, the following plans will increase Tier 3 copay by $10:
  - $10/$40/$60/20% will change to $10/$40/$**70**/20% (includes plans with an Rx deductible).
  - Ded/$10/$40/60/20% will change to Ded/$10/$40/$**70**/20%.

- Specialty drug trends continue to increase at a higher rate than other medications. As a result, the Tier 4 per script maximum for a 30-day prescription will change from $250 to $300. This change applies to all pharmacy plans with Tier 4 coinsurance, with one exception, plans with coinsurance on Tiers 1-4.

Plan retirements

Anthem evaluates our product portfolio annually to ensure we offer the most valuable plans to the market. Groups will be migrated to the closest plan design at renewal. Ask your Anthem representative for additional plan options as needed.

Retired 2020 plan	Migrate to 2021 plan
Elements Choice 5500/20%/7900 Rx $10/40/70/25%	30 5000/20%/7900 Rx $10/40/70/20%
Elements Choice HSA 5300/0%/5300 Rx 0%	HSA 5000/0%/6750 Rx $10/40/70/20%
HSA 1500NE/0%/3000 Rx $10/40/60/20%	HSA 2800/0%/4000 Rx $10/40/70/20%
KeyCare 500/20%/4000	25 500/20%/4000 Rx 10/40/70/20%
KeyCare 1000/20%/5000	30 1000/20%/4500 Rx $10/40/70/20%
KeyCare 1000/30%/5500	30 1000/30%/5000 Rx $10/40/70/20%
KeyCare 1500/20%/5500	30 1500/20%/5250 Rx $10/40/70/20%
KeyCare 2500/20%/6500	30 2500/20%/6500 Rx $10/40/70/20%
HRA 1500NE/0%/3000 Rx $10/40/60/20%	30 1000/20%/4500 Rx $10/40/70/20%
HRA 2500NE/0%/3950 Rx $10/40/60/20%	30 3000/20%/7000 Rx $15/50/85/20%
HRA 1500/20%/5000 Rx 20%	30 2000/20%/5500 Rx $10/40/70/20%
HRA 3000/0%/4000 Rx $10/40/60/20%	30 3000/20%/7000 Rx $15/50/85/20%
HRA 3000NE/0%/3950 Rx $10/40/60/20%	30 4000/20%/7350 Rx $15/50/85/20%
HRA 5000/0%/7000 Rx $10/40/60/20%	30 5000/20%/7350 Rx $15/50/85/20%

Legislative updates

Virginia's Legislative session took place in early 2020. There is some legislation that could impact groups at their renewal.

- **HB 66, which pertains to cost-sharing payments for prescription insulin drugs -** Carrier is required to limit member cost-share payment to not more than $50 per 30-day supply of prescription or $150 per 90-day supply of prescription insulin regardless of the amount or type of insulin needed to fill the covered person's prescription. This cost share limit applies to in-network pharmacy coverage only.

- **HB 1251/SB 172, which pertains to balance billing; payment to out-of-network providers -** Provides that when an enrollee receives *emergency services from an out-of-network health care provider or receives out-of-network surgical or ancillary services at an in-network facility*, the enrollee is not required to pay the out-of-network provider any amount other than the applicable cost-sharing requirement and such cost-sharing requirement cannot exceed the cost-sharing requirement that would apply if the services were provided in-network. The measure also ensures that the health carrier's required payment to the out-of-network provider of the services is a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area. If such provider disputes the amount to be paid by the health carrier, the measure requires the provider and the health carrier to make a good faith effort to reach a resolution on the amount of the reimbursement.

- **VA HB 1057, which pertains to Certified Nurse Specialist (CNS) coverage -** Prohibits health insurers and health service plan providers whose policies or contracts cover services that may be legally performed by a licensed clinical nurse specialist from denying reimbursement because the service is rendered by a licensed clinical nurse specialist. The measure removes the existing limitation that requires such reimbursement only to licensed clinical nurse specialists who render mental health services.

- **SB 605/HB 840, which pertains to formula and enteral nutrition products -** Requires coverage for medically necessary formula and enteral nutrition products as medicine and to include coverage for medically necessary formula and enteral nutrition products for individuals requiring treatment for an inherited metabolic disorder. The measure provides that the required coverage includes any medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products. These requirements apply only to formula and enteral nutrition products that are prescribed by a physician or other health care professional.

The following mandates required no changes to Anthem's coverage:

- **VA SB 718, which pertains to interhospital transfers of newborns and mothers -** Prohibits a health insurer from requiring prior authorization for the interhospital transfer of newborns experiencing a life-threatening emergency condition or the hospitalized mother of such newborn infant to accompany the infant.

- **VA HB 1273, which pertains to organ or tissue transplantation, discrimination prohibited -** Provides that an individual who is a candidate to receive an anatomical gift for organ, eye, or tissue transplantation, and who is otherwise eligible to receive such gift, shall not be deemed ineligible to receive an anatomical gift or denied such services solely because of his or her physical, intellectual, developmental, or other disability.

Member booklet updates

We update our booklets, effective for new sales and renewals, to help our members stay informed regarding their health plan benefits, as well as to make it clear what is excluded from plan coverage.

Note: This benefit overview is for illustrative purposes and some content may be pending Department of Insurance approval.
It is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.