



And Its Affiliate HealthKeepers, Inc.

Benefits You Can Count On

VCU Postdoctoral Fellows

HealthKeepers 25 POS Open Access Plan and

HealthKeepers Value Advantage 25/500/30 POS

Open Access Plan

Effective January 1, 2015

**Choosing the
right plan is a very
personal thing.**

Use this book to find one that's

- Right for your lifestyle
- Right for your needs
- Right for your peace of mind





Your guide to benefits

Welcome! We're so glad you're taking time to check out all that Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. (Anthem) has to offer you. Choosing your health care plan (and the benefits that go with it) is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with our Anthem plan. It shows what's available to you, what you get with each benefit and how the plan works. *Please note:* Anthem HealthKeepers benefits are provided through HealthKeepers, Inc. All other benefits are through Anthem Blue Cross and Blue Shield.

Explore the advantages of being an Anthem member.

This booklet goes into all the advantages. But here are the top four:

- 1. You're covered even when travel away from home.** You have access to the BlueCard® program and the BlueCard Worldwide® program so you'll be able to find an in-network doctor or hospital across the country or around the world if you need care. Wherever you travel, you can have peace of mind knowing you're covered.
- 2. You get more than just basic coverage.** You get access to tools, resources and guidance that are personalized just for you. Plus there are programs to help you get and stay healthy, some are even online. They'll help you reach your personal goals to be as healthy as possible.
- 3. There's so much you can do on our website – after all, it was created just for you.** If you have questions, you'll find the answers you're looking for. You can:
 - Order and print out a new member identification (ID) card if you lose yours,
 - Check the status of a claim
 - Find out how much a service costs
 - Search for a doctor, specialty, hospital or other health care professional
 - Learn about hundreds of health and wellness topics
 - And much more
- 4. Finding an in-network doctor, specialist, hospital or a list of your medicines is a snap.** Just go our website and search the Online Provider Directory. Or call the Customer Service number on your member ID card. A customer service representative can give you information by phone, e-mail, fax or mail.

Once you get your member ID card, all it takes is three simple steps to discover the world of anthem.com.

- Go to anthem.com
- Click on Register
- Create your user name and password

Then you're ready to go!

Your guide to benefits (continued)

We're on Facebook, Twitter and YouTube.

Did you know, that when you take better care of yourself, those around you will, too? Your health influences family, friends, even neighbors. (Studies prove it.) We're committed to helping you improve your health, wherever you go. And since you connect with friends, family, and coworkers — night and day, we've made it easy for you to connect with us.

- Facebook.com/HealthJoinIn
- Twitter.com/HealthJoinIn
- YouTube.com/HealthJoinIn



Scan the code with your mobile capable device for a direct link to anthem.com. Don't have a QR code reader? Download the free ScanLife app to your mobile device or visit scanlife.com.

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Helpful links

[anthem.com](#)

While you're there check out the Health and Wellness tab

[Facebook.com/HealthJoinIn](#)

While you're there check out the Health Personality Quiz

[Twitter.com/HealthJoinIn](#)

[YouTube.com/HealthJoinIn](#)

[Healthy Footprint](#)

[Glossary](#)

[Member Online Tools](#)

Summary of Benefits and Coverage

HealthKeepers

Anthem HealthKeepers 25 POS Open Access / \$10/\$30/\$50/20%

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 - 12/31/2015

Coverage For: Individual/Family | Plan Type: POS

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0 single / \$0 family for In-Plan Provider \$1000 single / \$2000 family for Out-of-Plan Provider Does not apply to Prescription Drugs, In-Plan Preventive Care, Copayments, Hospice and Routine Eye Exam. In-Plan Provider and Out-of-Plan Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; In-Plan Provider Single: \$4500, Family: \$9000 Out-of-Plan Provider Single: \$5500, Family: \$11000	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Balance-Billed Charges, Pre-Authorization Penalties, Health Care This Plan Doesn't Cover, Premiums, Out-of-Pocket Limit does not include Adult Routine Vision Care.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Questions: Call 1-855-333-5735 or visit us at www.anthem.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cclio.cms.gov or call 1-855-333-5735 to request a copy.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-855-333-5735 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness Specialist visit	\$25 copay \$50 copay	30% coinsurance 30% coinsurance	<u>Manipulative Therapy</u> Coverage is limited to 30 visits per year per member. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Services must be received by provider that participates in the American Specialty Health Network (ASHN).
	Other practitioner office visit	<u>Manipulative Therapy</u> \$25 copay <u>Acupuncturist</u> Not covered		
	Preventive care/screening/immunizations	No cost share	30% coinsurance	<u>Lab - Office</u> Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply. <u>X-Ray - Office</u> Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply.
If you have a test	Diagnostic test (x-ray, blood work)	<u>Lab - Office</u> \$25 copay <u>X-Ray - Office</u> \$25 copay		

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	20% coinsurance If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.anthem.com/pharmacyinformation/	\$10 copay/prescription (retail only) and \$25 copay/prescription (mail order only) Tier 1 – Typically Generic	Failure to obtain preauthorization may result in non-coverage or reduced coverage. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
			\$30 copay/prescription (retail only) and \$75 copay/prescription (mail order only) Tier 2 – Typically Preferred/Formulary Brand	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
			\$50 copay/prescription (retail only) and \$125 copay/prescription (mail order only) Tier 3 – Typically Non-preferred/non-Formulary Drugs	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Tier 4 – Typically Specialty Drugs	20% coinsurance (retail only) with \$200 max and 20% coinsurance (mail order only) with \$400 max	20% coinsurance (retail and mail order)	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
	If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center) Physician/Surgeon Fees	\$300 copay \$50 copay	30% coinsurance 30% coinsurance
	If you need immediate medical attention	Emergency Room Services Emergency Medical Transportation	\$250 copay \$150 copay	\$250 copay \$150 copay
	If you have a hospital stay	Urgent Care	\$25 copay	30% coinsurance
		Facility Fee (e.g., hospital room)	\$350 copay per day up to \$1750 per admission	30% coinsurance
		Physician/surgeon fee	No cost share	30% coinsurance
				none

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Mental/Behavioral health inpatient services	<u>Mental/Behavioral Health Office Visit</u> \$30 copay <u>Mental/Behavioral Health Facility Visit - Facility Charges</u> No cost share	<u>Mental/Behavioral Health Office Visit</u> 30% coinsurance <u>Mental/Behavioral Health Facility Visit - Facility Charges</u> 30% coinsurance	<u>Mental/Behavioral Health Office Visit</u> Medication management, individual therapy up to 30 minutes and group therapy sessions at - \$20 copay.
If you are pregnant	Substance use disorder outpatient services	<u>Substance Abuse Office Visit</u> \$30 copay <u>Substance Abuse Facility Visit - Facility Charges</u> No cost share	<u>Substance Abuse Office Visit</u> 30% coinsurance <u>Substance Abuse Facility Visit - Facility Charges</u> 30% coinsurance	<u>Substance Abuse Office Visit</u> Medication management, individual therapy up to 30 minutes and group therapy sessions at - \$20 copay.
If you need help recovering or have other special health needs	Delivery and all inpatient services Home Health Care	\$300 copay	\$300 copay 30% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care. Copay waived if readmitted for the same condition within less than 72 hours from discharge.
			20% coinsurance	30% coinsurance Coverage is limited to 100 visits per year.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Rehabilitation Services	\$25 copay	30% coinsurance	Coverage is limited to 30 visits per year for physical therapy and occupational therapy combined, 30 visits per year for speech therapy. Limit does not apply to autism services, if applicable. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Habilitation Services	\$25 copay	30% coinsurance	Rehabilitation and Habilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	20% coinsurance	30% coinsurance	Coverage is limited to 100 days per stay. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Durable medical equipment	20% coinsurance	30% coinsurance	_____none_____
	Hospice service	No cost share	30% coinsurance	_____none_____
¹³ If your child needs dental or eye care	Eye exam	\$15 copay	First \$30 is covered in full. After \$30, you pay 100% coinsurance after deductible	Coverage is limited to 1 occurrences per benefit period.
	Glasses	See Limitations and Exclusions	Not covered	Discounts on eyewear and lenses available at participating providers.
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Most coverage provided outside the United States. See www.bcbss.com/bluecardworldwide.
- Private-duty nursing
 - Routine foot care Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
 - Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
 - Routine eye care (adult) Coverage is limited to 1 screening exam. Consult your formal contract of coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the Department of Labor's Employee Benefits Security Administration

1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

HealthKeepers
ATTN: Appeals
P.O. Box 27401
Richmond, VA 23279
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Virginia Bureau of Insurance
1300 East Main Street
P. O. Box 1157
Richmond, VA 23218
800-552-7945

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

(877) 310-6560
<http://www.scc.virginia.gov/boi>
bureauofinsurance@scc.virginia.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as minimum essential coverage. This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigo eí dooda'i, shikáa adookwoh iinízningo t'áá diné k'éjígo, t'áá shoodí ba na'admíhí ya sidáhí bich'i naabídíhlíid. Eí doo bligha daago ni ba'nija'go ho'aalagii bich'i hodílhí. Haídqä iini'taago éiyá, t'áá shoodí diné ya atáh halne'igú ni béissh bee hane'i wólta' bi'ki si'niilgíi bi'kehgo bich'i hodílhí.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$6,340
- **Patient pays:** \$1,200

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Total Deductibles	\$0
Co-pays	\$790
Co-insurance	\$250
Limits or exclusions	\$80
Total	\$1,120
Total	\$1,200

This is
not a cost
estimator.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$4,280
- **Patient pays:** \$1,120

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Total Deductibles	\$0
Co-pays	\$790
Co-insurance	\$250
Limits or exclusions	\$80
Total	\$1,120
Total	\$1,200

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

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What does a Coverage Example show?

For each treatment situation, the Coverage

- Example helps you see how deductibles, copayments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

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Coverage For: Individual/Family | **Plan Type:** POS



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What is the overall deductible?	\$500 single / \$1000 family for In-Plan Provider \$1000 single / \$2000 family for Out-of-Plan Provider Does not apply to Prescription Drugs, In-Plan Preventive Care, Copayments, Hospice, Manipulative Services, Office Based Lab and Routine Eye Exam. In-Plan Provider and Out-of-Plan Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the deductible starts over (usually, but not always, January 1st.) See the chart starting on page 3 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; In-Plan Provider Single: \$4500, Family: \$9000 Out-of-Plan Provider Single: \$6250, Family: \$12500	The out-of-pocket limit is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Balance-Billed Charges, Pre-Authorization Penalties, Health Care This Plan Doesn't Cover, Premiums, Out-of-Pocket Limit does not include Adult Routine Vision Care.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the insurer pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-855-333-5735 for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Plans use the terms in-network, preferred, or participating to refer to providers in their network.
Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about excluded services.



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness Specialist visit	\$25 copay \$50 copay	30% coinsurance 30% coinsurance	<u>Manipulative Therapy</u> Coverage is limited to 30 visits per year per member. <u>Acupuncture</u> 30% coinsurance Not covered
	Other practitioner office visit	<u>Manipulative Therapy</u> \$25 copay <u>Acupuncturist</u> Not covered		<u>Manipulative Therapy</u> Coverage is limited to 30 visits per year per member. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Services must be received by provider that participates in the American Specialty Health Network (ASHN).
	Preventive care/screening/immunizations	No cost share	30% coinsurance	<u>Lab - Office</u> Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply.
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	<u>Lab - Office</u> 30% coinsurance <u>X-Ray - Office</u> 30% coinsurance 30% coinsurance	<u>Lab - Office</u> 30% coinsurance <u>X-Ray - Office</u> 30% coinsurance 30% coinsurance	<u>Lab - Office</u> Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply. Failure to obtain preauthorization may result in non-coverage or reduced coverage.

Common Medical Event	Services You May Need If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.anthem.com/pharmacyinformation/	Your Cost If You Use a In-Plan Provider Tier 1 – Typically Generic \$10 copay/ prescription (retail only) and \$25 copay/prescription (mail order only)	Your Cost If You Use a Out-of-Plan Provider \$10 copay/ prescription (retail only) and \$25 copay/prescription (mail order only)	Limitations & Exceptions
		<p>Tier 2 – Typically Preferred/Formulary Brand</p> <p>\$30 copay/ prescription (retail only) and \$75 copay/prescription (mail order only)</p>	<p>If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions.</p> <p>Using a Non-Network provider may result in increased cost sharing.</p> <p>Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)</p>	
		<p>Tier 3 – Typically Non-preferred/non-Formulary Drugs</p> <p>\$50 copay/ prescription (retail only) and \$125 copay/prescription (mail order only)</p>	<p>If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions.</p> <p>Using a Non-Network provider may result in increased cost sharing.</p> <p>Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)</p>	

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Tier 4 – Typically Specialty Drugs	20% coinsurance (retail only) with \$200 max and 20% coinsurance (mail order only) with \$400 max	20% coinsurance (retail and mail order)	If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. Using a Non-Network provider may result in increased cost sharing. Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (mail order program)
If you have outpatient Surgery	Facility Fee (e.g., ambulatory surgery center) Physician/Surgeon Fees	30% coinsurance 30% coinsurance	30% coinsurance 30% coinsurance	_____none_____ _____none_____
If you need immediate medical attention	Emergency Room Services Emergency Medical Transportation	30% coinsurance 30% coinsurance	30% coinsurance \$25 copay	No coverage for non emergency use of emergency room. _____none_____
If you have a hospital stay	Facility Fee (e.g., hospital room) Physician/surgeon fee	30% coinsurance 30% coinsurance	30% coinsurance 30% coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. Failure to obtain preauthorization may result in non-coverage or reduced coverage. _____none_____

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Mental/Behavioral health inpatient services	<u>Mental/Behavioral Health Office Visit</u> \$25 copay <u>Mental/Behavioral Health Facility Visit - Facility Charges</u> 30% coinsurance <u>Mental/Behavioral Health Office Visit</u> 30% coinsurance	<u>Mental/Behavioral Health Office Visit</u> 30% coinsurance <u>Mental/Behavioral Health Facility Visit - Facility Charges</u> 30% coinsurance <u>Mental/Behavioral Health Office Visit</u> 30% coinsurance	<u>Mental/Behavioral Health Office Visit</u> 30% coinsurance <u>Mental/Behavioral Health Facility Visit - Facility Charges</u> 30% coinsurance <u>Mental/Behavioral Health Office Visit</u> 30% coinsurance
				<u>Substance Abuse Office Visit</u> \$25 copay <u>Substance Abuse Facility Visit - Facility Charges</u> 30% coinsurance <u>Substance Abuse Office Visit</u> 30% coinsurance <u>Substance Abuse Facility Visit - Facility Charges</u> 30% coinsurance <u>Substance Abuse Office Visit</u> 30% coinsurance <u>Prenatal and postnatal care</u> <u>Delivery and all inpatient services</u>
				Your doctor's charges for delivery are part of prenatal and postnatal care. <u>Home Health Care</u> 30% coinsurance Coverage is limited to 100 visits per year.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Plan Provider	Your Cost If You Use a Out-of-Plan Provider	Limitations & Exceptions
	Rehabilitation Services	30% coinsurance	30% coinsurance	Coverage is limited to 30 visits per year for physical therapy and occupational therapy combined, 30 visits per year for speech therapy. Limit does not apply to autism services, if applicable. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Habilitation Services	30% coinsurance	30% coinsurance	Rehabilitation and Habilitation visits count towards your Rehabilitation limit.
	Skilled Nursing Care	30% coinsurance	30% coinsurance	Coverage is limited to 100 days per stay. Services from In-Plan Provider and Out-of-Plan Provider count towards your limit.
	Durable medical equipment	30% coinsurance	30% coinsurance	_____none_____
	Hospice service	No cost share	30% coinsurance	_____none_____
²⁵ If your child needs dental or eye care	Eye exam	\$15 copay	First \$30 is covered in full. After \$30, you pay 100% coinsurance after deductible	Coverage is limited to 1 occurrences per benefit period.
	Glasses	See Limitations and Exclusions	Not covered	Discounts on eyewear and lenses available at participating providers.
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long- term care
- Most coverage provided outside the United States. See www.bcbss.com/bluecardworldwide.
- Private-duty nursing
 - Routine foot care Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.
 - Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
 - Routine eye care (adult) Coverage is limited to 1 screening exam. Consult your formal contract of coverage.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-333-5735. You may also contact your state insurance department, the Department of Labor's Employee Benefits Security Administration

1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

HealthKeepers
ATTN: Appeals
P.O. Box 27401
Richmond, VA 23279

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

Virginia Bureau of Insurance
1300 East Main Street
P. O. Box 1157
Richmond, VA 23218
800-552-7945

(877) 310-6560
<http://www.scc.virginia.gov/boi>
bureauofinsurance@scc.virginia.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as minimum essential coverage. This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigo eí dooda'i, shikáa adookwoh iiníziniго t'áa diné k'éjígo, t'áa shoodí ba na'admíhí ya sidáhí bich'i naabídíhlíid. Eí doo bligha daago ni ba'nija'go ho'aalagii bich'i hodílhí. Haídäq iini'taago éiyá, t'áa shoodí diné ya atáh halne'igú ni béissh bee hane'i wólta' bi'ki si'niilgíi bi'kehgo bich'i hodílhí.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$4,840
- **Patient pays:** \$2,700

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Total Deductibles	\$500
Co-pays	\$630
Co-insurance	\$350
Limits or exclusions	\$80
Total	\$1,560

This is not a cost estimator.



Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$3,840
- **Patient pays:** \$1,560

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Total Deductibles	\$500
Co-pays	\$630
Co-insurance	\$350
Limits or exclusions	\$80
Total	\$1,560

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

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What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and co-insurance can add up.

- It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Questions: Call 1-855-333-5735 or visit us at www.anthem.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-333-5735 to request a copy.

Your Health Benefits

Anthem HealthKeepers POS Open Access Plan

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

One, you have options. Anthem HealthKeepers POS is a Point-of-Service plan, which means you're free to choose doctors in or out-of-plan. This plan also includes an Open Access feature which allows you to seek specialist services without referrals. Of course, in-plan care will usually cost less than out-of-plan care. The Anthem HealthKeepers network includes many doctors and hospitals across Virginia, so you'll find plenty of choices. The point is, the choice is yours.

A primary doctor gives you the guided coverage of an HMO. Yet you can still go out-of-plan. That's flexible.

Two, as an Anthem HealthKeepers member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions – for you, your health and your budget.

Anthem HealthKeepers POS Open Access at a glance

- **Primary Care Physicians (PCPs):** Flexible
Your PCP provides preventive care and can be an advocate for helping you decide what types of specialist services may be of value to you. You can change your PCP as often as monthly, allowing you to "try on" different provider offices.
- **Referrals:** Not needed.
- **Claim Forms:** No claim forms to submit when using network providers.
- **Out-of-Plan Benefits:** Available for most services, but at more cost than when using in-plan providers. We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- **Out-of-Pocket:** This is the amount you'll pay, whether it is a straight copayment or some percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

Through anthem.com, you can estimate the costs for inpatient and outpatient services and doctor visits. What better way to help you determine what to do?

Anthem HealthKeepers POS Open Access Plan (continued)

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency, urgent or approved follow-up care, you have three options. Go to anthem.com, call BlueCard® Access at 800-810-2583 or call the customer service number on your member ID card.

You're getting more than a health plan

You get programs to actually help you manage your health. Wellness tools, 360° Health® health management programs and SpecialOffers@Anthem are all available through anthem.com. The programs are explained in detail later in this booklet. This is a brief overview of your plan's features. Your benefits summary contains the details. Thank you for considering Anthem HealthKeepers.

How to find a network doctor

Simply go online and search our provider directory for the type of care you need.

1. Go to [anthem.com](#).
2. Select "Find a Doctor."
3. Enter your city and state or zip and click on "Search."
4. To see only a list of network providers, scroll down to "Insurance Options" and select "Add/Edit Selections."
5. Enter your state, select the HMO plan, then select "Anthem HealthKeepers" and click on "Search."

Your Benefits



Anthem HealthKeepers

Anthem HealthKeepers 25 POS

Covered 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 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.	*No Charge
Doctor Visits <input type="radio"/> office visits <input type="radio"/> urgent care visits <input checked="" type="checkbox"/> <input type="radio"/> in-office surgery <input type="radio"/> home visits <input type="radio"/> voluntary family planning	\$25 for each visit to your PCP \$50 for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests <input type="radio"/> diagnostic tests <input type="radio"/> diagnostic x-rays <input type="radio"/> lab work <i>*This fee is not required when these services are provided by the same professional on the same day as the office visit.</i>	\$25 for each visit to your PCP \$50 for each visit to a specialist
<input type="radio"/> advanced diagnostic imaging services	20% of the amount the health care professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD) – For children from age 2 through 6 <input type="radio"/> diagnosis and treatment of autism spectrum disorder including: <input type="radio"/> behavioral health treatment* <input type="radio"/> pharmacy care <input type="radio"/> psychiatric care <input type="radio"/> psychological care <i>* Mental Health Services</i> <i>**Unlimited physical, occupational and speech therapy.</i>	Member cost shares will be dependent on the services rendered.
<input type="radio"/> applied behavioral analysis <input type="radio"/> limited to a \$35,000 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 <input type="radio"/> Unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.
Other Outpatient Services <input type="radio"/> hospice care	No Charge
<input type="radio"/> diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered.
<input type="radio"/> ambulance travel	\$150 per transport
<input type="radio"/> prosthetic devices <input type="radio"/> durable medical equipment <input type="radio"/> home health care (100 visits) <input type="radio"/> injectable medication* (excluding immunizations, preventive care, allergy injections and serum dispensed in a physician's office) <i>*You will also pay an additional \$25 or \$50 office visit copayment depending on the type of provider who treats you.</i>	20% of the amount the health care professionals in our network have agreed to accept for their services

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"> ○ physical and occupational therapy (30 combined visits)* ○ spinal manipulation and manual medical therapy services (30 visit limit) ○ speech therapy (30 visit limit)* <p><i>*Limit does not apply to Autism Spectrum Disorder.</i></p>	\$25 for each visit
<ul style="list-style-type: none"> ○ chemotherapy, radiation, cardiac and respiratory therapy 	\$50 for each visit
<ul style="list-style-type: none"> ○ dialysis 	20% of the amount 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 	\$50 for each visit
<ul style="list-style-type: none"> ○ home services 	20% of the amount 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 	\$300 for each visit
Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> ○ skilled nursing facility (100 days for each admission) 	20% of the amount health care professionals in our network have agreed to accept for their services
<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>	\$350 per day (not to exceed \$1,750) for an admission *
Maternity	
<ul style="list-style-type: none"> ○ all routine pre- and postnatal care (excluding inpatient stays) 	\$300 per pregnancy
<ul style="list-style-type: none"> ○ diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures) 	\$50 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 	\$20 for each visit
<ul style="list-style-type: none"> ○ other mental health and substance use visits 	\$30 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 	\$50 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>	\$250 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 \$1,000 in one calendar year. If two or more people are covered under your health plan, each member will be responsible for paying the first \$1,000 toward covered services within a calendar year.

- If two people are covered under your plan, each of you will pay the first \$1000 of the cost of your care (\$2,000 total).
- If three or more people are covered under your plan, together you will pay the first \$2,000 of the cost of your care.
However, the most one family member will pay is \$1,000.

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 \$1,000 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 \$4,500 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 \$4,500 (\$9,000 total).
- If three or more people are covered under your plan, together you will pay \$9,000. However, no family member will pay more than \$4,500 toward the limit.

When using out-of-plan professionals

If you are the only one covered by your plan, you will pay \$5,500 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 \$5,500 (\$11,000 total).
- If three or more people are covered under your plan, together you will pay \$11,000. However, no family member will pay more than \$5,500 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.



Your Benefits

Anthem HealthKeepers Value Advantage 25/500/30 POS Open Access Plan

In-Plan 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 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.	*No Charge
Routine Vision ○ annual routine eye exam <i>Plus – valuable discounts on eyewear</i>	\$15 for each visit
Doctor Visits ○ office visits ○ home visits <i>* If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)</i>	\$25 for each visit to your PCP \$50 for each visit to a specialist
○ mental health and substance use visits	\$25 for each visit
Spinal Manipulation ○ spinal manipulations and manual medical therapy services <i>(Limited up to 30 visits per calendar or plan year)</i>	\$25 for each visit

All Other In-Plan Services

You will pay all the costs associated with your care until you have paid \$500 in one calendar or plan year. This is known as your deductible.

- If two people are covered under your plan, each of you will pay the first \$500 of the cost of your care (\$1,000 total).
- If three or more people are covered under your plan, together you will pay the first \$1,000 of the cost of your care. However, the most one family member will pay is \$500.

Once you reach your deductible you pay:

Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
○ diagnosis and treatment of autism spectrum disorder including: ○ behavioral health treatment* ○ pharmacy care ○ psychiatric care ○ psychological care ○ therapeutic care**	Member cost shares will be dependent on the services rendered.
<i>* Mental Health Services</i> <i>**Unlimited physical, occupational and speech therapy.</i>	
○ applied behavioral analysis ○ limited to a \$35,000 per member annual maximum	30% 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	
○ unlimited per member per calendar year up to age 3	Member cost shares will be dependent on the services rendered.

SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.

Your benefit period may be a calendar year or a plan year. A calendar year means your benefit period runs from January through December while a plan year runs from the effective date of the plan through a 12-month period (e.g. February 1 through January 31 or July 1 through June 30). Check with your employer to learn whether your benefits will be calculated on a calendar year or plan year basis.

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

In-Plan Services	You Pay
Other Outpatient Services <ul style="list-style-type: none"> <input type="radio"/> ambulance travel <input type="radio"/> dialysis <input type="radio"/> in-office surgery <input type="radio"/> medical appliances, supplies and medications, including infusion medications <input type="radio"/> physical and occupational therapy visits in an office setting (30 combined visits)** <input type="radio"/> x-rays <p>*Other than outpatient lab and pathology services/tests performed by an HMO laboratory provider</p> <p>**Limit does not apply to Autism Spectrum Disorder.</p>	<ul style="list-style-type: none"> <input type="radio"/> chemotherapy, IV, radiation, cardiac and respiratory therapy <input type="radio"/> durable medical equipment <input type="radio"/> lab services* <input type="radio"/> mental health and substance use partial-day treatment programs <input type="radio"/> speech therapy visits in an office setting (30 visit limit)** <input type="radio"/> shots and therapeutic injections <p>30% of the amount the health care professionals in our plan have agreed to accept for their services</p>
<ul style="list-style-type: none"> <input type="radio"/> diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
Emergency Care and Out of the Service Area Urgent Care <ul style="list-style-type: none"> <input type="radio"/> urgent care visits <input type="radio"/> true emergency care visits in or out of the service area 	<p>\$25 for each visit to your PCP \$50 for each visit to a specialist</p> <p>30% of the amount health care professionals in our plan have agreed to accept for their services</p>
Outpatient Visits in a Hospital or Facility <ul style="list-style-type: none"> <input type="radio"/> physical therapy and occupational therapy (30 combined visits per calendar or plan year)* <input type="radio"/> speech therapy (30 visits per calendar or plan year)* <input type="radio"/> surgery <p>*Limit does not apply to Autism Spectrum Disorder.</p>	30% of the amount the health care professionals in our plan have agreed to accept for their services
Care at Home <ul style="list-style-type: none"> <input type="radio"/> home health care (100 visits) <input type="radio"/> private duty nursing limited to 16 hours per member per calendar year <input type="radio"/> hospice care 	<p>30% of the amount the health care professionals in our plan have agreed to accept for their services</p> <p>No charge</p>
Inpatient Stays in a Plan Hospital or Facility <ul style="list-style-type: none"> <input type="radio"/> semi-private room, intensive care or similar unit <input type="radio"/> physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services <input type="radio"/> skilled nursing facility care (100 days per each admission) 	30% of the amount the health care professionals in our plan have agreed to accept for their services
Out-of-Plan Services	
Using doctors, hospitals and other health care professionals not contracted to provide benefits	
<p>It's important to remember that health care professionals not in our plan can charge whatever they want for their services. If what they charge is more than the fee our plan 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 \$1,000 in one calendar or plan year. This is called your out-of-plan deductible.</p> <ul style="list-style-type: none"> <input type="radio"/> If two people are covered under your plan, each of you will pay the first \$1,000 of the cost of your care (\$2,000 total). <input type="radio"/> If three or more people are covered under your plan, together you will pay the first \$2,000 of the cost of your care. However, the most one family member will pay is \$1,000. <p>Once you have reached this amount, when you receive covered services we will pay 70% of the fee our plan health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our plan health care professionals have agreed to accept for the same service and the amount the health care professional not in our plan charges. If you go to an eye care professional not in our plan for your routine eye examination, we will pay \$30 (whether or not you have reached the \$1,000 out-of-plan deductible) and you will pay the rest of what the professional charges.</p>	

Out-of-Pocket Maximums

What you will pay for covered services in one calendar or plan year

When using in-plan professionals

If you are the only one covered by your plan, you will pay \$4,500 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 \$4,500 (\$9,000 total).
- If three or more people are covered under your plan, together you will pay \$9,000. However, no family member will pay more than \$4,500 toward the limit.

When using out-of-plan professionals

If you are the only one covered by your plan, you will pay \$6,250 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 \$6,250 (\$12,500 total).
- If three or more people are covered under your plan, together you will pay \$12,500. However, no family member will pay more than \$6,250 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.

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 retail 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 66785
St. Louis MO 63166-6785

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. They include (but are not limited to):

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

Your prescription drug plan (continued)

- 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.
- 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.”

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.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliates, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association.®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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.

Take care of yourself. Use your preventive care benefits.



And Its Affiliate HealthKeepers, Inc.

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.¹ When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Vision screening² when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women's preventive care

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met⁶
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)^{3,4}
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening⁴
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV⁴
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision²
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles)

A word about pharmacy items

For 100% coverage of over-the-counter (OTC) drugs and other pharmacy items listed below, the person receiving the item(s) must meet the age and other specified criteria. You need to work with your in-network doctor or other health care provider to get a prescription for the item(s) and take the prescription to an in-network pharmacy. Even if the item(s) do not "need" a prescription to purchase them, if you want the item(s) covered at 100%, you have to have the prescription.

Child preventive drugs and other pharmacy items — age appropriate

- Fluoride supplements for children from birth through 6 years old
- Iron supplements for children 0-12 months

Adult preventive drugs and other pharmacy items — age appropriate

- Aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco cessation products including select generic prescription drugs, select brand-name drugs with no generic alternative, and FDA-approved over-the-counter products, for those 18 and older

Women's preventive drugs and other pharmacy items — age appropriate

- Contraceptives including generic prescription drugs, brand-name drugs with no generic alternative, and over-the-counter items like female condoms or spermicides^{4,5}
- Folic acid for women 55 years old or younger
- Vitamin D for women over 65
- Breast cancer risk-reducing medications following the U.S. Preventive Services Task Force criteria (such as tamoxifen and raloxifene)⁷

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Customer Service number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

4 This benefit also applies to those younger than 19.

5 A cost share may apply for other prescription contraceptives, based on your drug benefits.

6 Check your medical policy for details.

7 Requires prior authorization. Coverage begins October 1, 2014.

Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting our networks with those of other Blue Cross and Blue Shield companies across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com or call the member services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. Call member services to verify your coverage.
3. Show your ID card at the time of service.
4. You can access the BlueCard network for office visits and other services when you are out of the area. However, please note that only emergency services will be covered at the in-network level. All other services will be subject to out-of-network benefits..

One additional step. No additional costs or hassles. You pay the same with any Blue Cross and Blue Shield provider as you would a network provider. Plus the provider will file your claims for you. We will still mail your explanation of benefits so you can double-check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.

Ins and Outs of Coverage

The ins and outs of coverage

Knowing that you have health care coverage that meets your and your family's needs is reassuring.

But part of your decision in choosing a plan also requires understanding:

- who can be enrolled
- how coverage changes are handled
- what's not covered by your plan
- how your plan works with other coverage

Who can be enrolled

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- Your spouse
- Your children age 26 or younger, which includes:
 - A newborn, natural child or a child placed with you for adoption
 - A stepchild, or
 - Any other child for whom you have legal guardianship

Coverage will end on the last day of the month in which they turn 26.

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 26.

The ins and outs of coverage (continued)

1. On the employer level — which impacts you as well as all employees under your employer's plan — your plan can be ...

renewed	cancelled	changed	when ...
●			your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	●		your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	●		we decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		●	your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Lumenos coverage.

2. On an individual level — factors that apply to you and covered family members — your plan can be ...

renewed	cancelled	when ...
●		you maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	●	you purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	●	you lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.



The ins and outs of coverage (continued)

Special enrollment periods

Typically you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is first offered to you as a "new hire" or during your employer's open enrollment period when employees can make changes to their benefits for an upcoming year. But there may be instances other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

When you're covered by multiple plans

If you're fortunate enough to be covered by more than one health plan, you may not be so thrilled about the paperwork hassles that can come with it when you're trying to figure out which plan should pay for what. Our Coordination of Benefits (COB) program helps ensure that you receive the benefits due and avoid overpayment by either carrier. Because up-to-date, accurate information is the key to our Coordination of Benefits program, you can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

If you are covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay a claim and provide reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.

The ins and outs of coverage (continued)

Determining the primary versus secondary carrier

See the chart below for how determination gets made over which health plan is the primary carrier. The term "participant" is used and means the person who is signing up for coverage:

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	●	
	The plan with COB is		●
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	●	
	The plan covering the person as a dependent is		●
The person is the participant in two active group plans	The plan that has been in effect longer is	●	
	The plan that has been in effect the shorter amount of time is		●
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	●	
	The COBRA plan is		●
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	●	
	The non-custodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

The ins and outs of coverage (continued)

How benefits apply when Medicare-eligible

Some people under age 65 are eligible for Medicare in addition to any other coverage they may have. The following chart shows how payment is coordinated under various scenarios:

When a person is covered by Medicare and a group plan, and	Then	Your Anthem Plan	Medicare is Primary
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	●	
	Upon completion of the 30-month Medicare entitlement period		●
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	●	
	If Medicare had been primary to the group plan before ESRD entitlement		●

Recovery of overpayments

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

- any person to or for whom the overpayments were made;
- any health care company; and
- any other organization.

The ins and outs of coverage (continued)

What's not covered (exclusions)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them from. But, in order for us to keep the cost of health care as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered in any case.

acupuncture

services not **authorized in advance** by us and pre-arranged by your primary care physician unless otherwise specific in this book

biofeedback therapy

over-the-counter **convenience** and hygienic items including, but not limited to, adhesive removers, cleansers, underpads, and ice bags

cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by HealthKeepers, Inc. Other dental services not covered by your plan include the following as noted below:

- shortening or lengthening of the mandible or maxillae for cosmetic purposes;
- surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services;
- dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia;
- medications to treat periodontal disease;
- treatment of natural teeth due to diseases;
- biting and chewing related injuries;
- restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth;
- extraction of either erupted or impacted wisdom teeth; and
- anesthesia and hospitalization for dental procedures and services except as specified within the Evidence of Coverage you will receive after enrollment.

The ins and outs of coverage (continued)

donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child, sibling)

experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. This will not prevent a member from being able to appeal Anthem's decision that a service is not experimental/investigative.

family planning

- artificial insemination services, in vitro fertilization or any other types of artificial or surgical means of conception, including drugs administered in connection with these procedures
- drugs used to treat infertility
- non-prescription contraceptive devices
- any services or supplies provided to a person not covered that is in connection with a surrogate pregnancy, including but not limited to, the bearing of a child by another woman for an infertile couple
- services to reverse voluntarily induced sterility

services for palliative or cosmetic **foot** care

- flat foot conditions
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- foot orthotics
- subluxations of the foot
- corns, calluses and care of toenails (except in treatment for patients with diabetes or vascular disease)
- bunions (except capsular or bone surgery)
- fallen arches, weak feet, chronic foot strain
- symptomatic complaints of the feet

Experimental ... or not?

Many of the Anthem HealthKeepers medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

- regulatory approval from the Food and Drug Administration;
- been put through extensive research study to find all the benefits and possible harms of the technology;
- benefits that are far better than any potential risks;
- at least the same or better effectiveness as any similar service or procedure already available; and
- been tested enough so that we can be certain it will result in positive results when used in real cases.

The ins and outs of coverage (continued)

services for surgical treatments of **gynecomastia** for cosmetic purposes

health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

hearing care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

home care services

- homemaker services (except as rendered as part of Hospice care)
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services

- guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay
- care by interns, residents, house physicians, or other facility employees that are billed separately from the facility
- a private room unless it is medically necessary

immunizations required for travel or work, unless such services are received as part of the covered preventive care services

medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use:

- exercise equipment
- air conditioners, dehumidifiers, humidifiers, and purifiers
- hypoallergenic bed linens
- whirlpool baths
- handrails, ramps, elevators, and stair glides
- telephones
- adjustments made to a vehicle
- foot orthotics
- changes made to a home or place of business
- repair or replacement of equipment you lose or damage through neglect

medical equipment (durable) that is not appropriate for use in the home



The ins and outs of coverage (continued)

services or supplies deemed not **medically necessary** as determined by the HMO at its sole discretion. Notwithstanding this exclusion, all wellness services and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by Anthem HealthKeepers to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal the HMO's decision that a service is not medically necessary.

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual deviation and dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
 - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital
 - group psychotherapy when there are more than 8 patients with a single therapist
 - group psychotherapy when there are more than 12 patients with two therapists
 - more than 12 convulsive therapy treatments during a single admission
 - psychotherapy provided on the same day of convulsive therapy

services from **non-HMO providers**, except for emergencies when authorized in advance by the HMO Medical Director (this exclusion does not pertain to Point of Service plans or for an annual routine eye exam from an out-of-network provider)

The ins and outs of coverage (continued)

nutrition counseling and related services, except when provided as part of diabetes education or when received as part of a covered wellness services visit or screening

nutritional and/or dietary supplements, except as specifically listed in this enrollment brochure or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

obesity services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

paternity testing

prescription drug benefits

- over-the-counter drugs
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the allowable charge for that prescription
- drugs for weight loss
- stop smoking aids
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- infertility medication
- any refill dispensed after one year from the date of the original prescription order
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

- medicine furnished by any other drug or medical service

rest cures, custodial, residential or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic service.

services or supplies or devices

- ordered by a doctor whose services are not covered under your health plan
- not listed as covered under your health plan
- not prescribed, performed, or directed by a provider licensed to do so
- received before the effective date or after a covered person's coverage ends for injuries or illnesses incurred as a result of your commission of, or attempt to, commit a crime
- services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self
- benefits for charges from stand-by physicians in the absence of covered services being rendered
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies if provided or available to a member:

- under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this plan have been paid.
- provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government.

services for which a charge is not usually made including those services for which you would not have been charged if you did not have health care coverage services or benefits for:

- amounts above the allowable charge for a service
- for which a charge is not usually made, including those not typically charged to members without coverage
- self-administered services or self care including self-administered injections
- self-help training
- neurofeedback, and related diagnostic tests

services or supplies primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered wellness services visit or screening

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

sexual dysfunction surgery or sex transformation services, including medical and mental health services

services of non-HMO providers except for emergencies or when authorized in writing by our Medical Director including services not pre-arranged by your primary care physician and authorized in advance by us:

- women in at least their second trimester of pregnancy can continue to see their doctors who have left the Anthem HealthKeepers network, unless the doctors were asked to leave for cause
- members with a terminal illness who are expected to live less than six months can continue to see their doctors who have left the Anthem HealthKeepers network, unless the doctors were asked to leave for cause (this exclusion does not apply to Point of Service plans)

skilled nursing facility stays

- treatment of psychiatric conditions and senile deterioration
- facility services during a temporary leave of absence from the facility
- a private room unless it is medically necessary

smoking cessation programs not affiliated with us

spinal manipulation and manual medical therapy services (chiropractic care)

- any treatment or service not authorized by American Specialty Health Network, Inc. (ASHN)
- any service or treatment not provided by an ASHN provider (this exclusion does not apply to Point of Service plans) services for examination and/or treatment of strictly nonneuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment
- laboratory tests, x-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate or classified as experimental/investigative or in the research stage
- diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning, thermography
- educational programs, non-medical self-care and or self-help, or any self-help physical exercise training or
- any related diagnostic training
- air conditioners, air purifiers, therapeutic mattresses, supplied or any similar devices or appliances
- vitamins, mineral, nutritional supplements or any other similar type product

telemedicine

- non-interactive telemedicine services, including audio only telephone, electronic mail message or facsimile transmission

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

therapies

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- group speech therapy
- group or individual exercise classes or personal training sessions
- recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

services for treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes

vision services

- vision services or supplies unless needed due to eye surgery and accidental injury routine vision care and materials
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- sunglasses or safety glasses and accompanying frames of any type
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames
- any blended lenses (no line), oversize lenses, progressive multifocallenses, photchromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- any other vision services not specifically listed as covered

weight loss programs whether or not they are pursued under medical or physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

services or supplies if they are for work-related injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

These services are not covered by your Anthem HealthKeepers plan.



Additional Benefits

Additional Benefits

Blue View VisionSM

Vision care is not just for eyeglass wearers. Routine eye visits are important for everyone in preventing eyesight damage. In fact, eye exams can also help detect other health problems. Blue View Vision exists so you can get the vision care you need without feeling like you're busting your budget.

Advantages of Anthem Blue View Vision:

- **You have access to eye doctors close to you.** Blue View Vision has 44,000 eye doctors and locations in its network. If you don't already have a favorite, you can quickly find one. Plus, many retail locations, like LensCrafters®, Target® Optical, Sears Optical and Pearle Vision®, are covered by the plan. Finding a Blue View Vision network provider is easy — simply visit anthem.com.
- **You can get an eye exam every year.** Not every other year like other plans. Blue View Vision helps pay for eye exams annually.
- **Not many plans are this simple.** Just schedule an appointment with a network provider and present your member ID card when you arrive. The doctor's office staff will take care of the rest. And in most instances, you just need to pay a low copayment.
- **You save even more with additional discounts.** Want a frame that costs more than your plan allows? You save 20 percent off the balance. Want spare glasses, contact lenses or prescription sunglasses? Save 15 to 40 percent. Your additional discounts are unlimited — even after your vision care benefits have exhausted.
- **You've always got someone to help.** If you're seeing your eye doctor at night or on weekends, that's when we should be available to help you. So we're open Monday through Saturday, 8 a.m. to 11 p.m. Eastern time *and* Sunday 11 a.m. to 8 p.m. Eastern time. Or you can reach the interactive voice response system most any time of the day.

What happens if you use an eye professional not in the network?

You're still covered. You'll be asked to pay the full cost for services at the time of your appointment. When you mail in your receipt and other paperwork to Anthem, you'll get paid back for what the plan covers. To save the most money and have less hassle, try to use an eye doctor or retail location in the network.

This is a brief overview of your plan's features. Your summary of benefits contains the details. See your benefits manager if you need a copy. Thank you for considering Anthem Blue Cross and Blue Shield.

WELCOME TO BLUE VIEW VISION!

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!



And Its Affiliate HealthKeepers, Inc.

Blue View VisionSM BVV 130-25 12/24

Your Blue View Vision network

Blue View Vision members have access to one of the nation's largest vision networks. Blue View Vision is the only vision plan that gives members the ability to use their in-network benefits at 1-800 CONTACTS, or choose a private practice eye doctor, or go in store to LensCrafters[®], Sears OpticalSM, Target Optical[®], JCPenney[®] Optical and most Pearle Vision[®] locations.

Out-of-network: If you choose to, you may receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

VISION PLAN BENEFITS

Routine eye exam once every calendar year

Eyeglass frames

Once every two calendar years you may select an eyeglass frame and receive an allowance toward the purchase price

Eyeglass lenses (Standard)

Once every calendar year you may receive any one of the following lens options:

- Standard plastic single vision lenses (1 pair)
- Standard plastic bifocal lenses (1 pair)
- Standard plastic trifocal lenses (1 pair)

Eyeglass lens enhancements

When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost.

- **Transitions** Lenses (for a child under age 19)
- Standard Polycarbonate (for a child under age 19)
- Factory Scratch Coating

Contact lens fit and follow-up

A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.

- Standard contact lens fitting¹

IN-NETWORK

\$15 copay

- Premium contact lens fitting²

\$130 allowance, then 20% off any remaining balance

\$25 copay
\$25 copay
\$25 copay

OUT-OF-NETWORK

\$30 allowance

\$45 allowance

\$25 allowance
\$40 allowance
\$55 allowance

Contact lenses – once every calendar year

Prefer contact lenses over glasses? You may choose contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses.

- Elective Conventional Lenses; or
- Elective Disposable Lenses; or
- Non-Elective Contact Lenses

\$0
10% off retail price,
then apply \$55 allowance

\$130 allowance, then 15% off any remaining balance
\$130 allowance
(no additional discount)

Covered in full

\$35 allowance
\$35 allowance

\$105 allowance
\$105 allowance

\$210 allowance

¹ Standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

² Premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Your contact lens allowance can only be applied toward the first purchase of contacts you make during a benefit period. Any unused amount remaining cannot be used for subsequent purchases made during the same benefit period, nor can any unused amount be carried over to the following benefit period.

Blue View Vision Member Exclusive! You may use your in-network benefit to order your contact lenses from 1800 CONTACTS[®]. 1-800 CONTACTS offers a huge in-stock inventory, unbeatable prices, outstanding customer service and free shipping. Just call 1-800 CONTACTS or go to 1800contacts.com for fast and easy ordering of your contact lenses.

EXCLUSIONS & LIMITATIONS (not a comprehensive list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.

Excess Amounts. Amounts in excess of covered vision expense.

Sunglasses. Sunglasses and accompanying frames.

Safety Glasses. Safety glasses and accompanying frames.

Not Specifically Listed. Services not specifically listed in this plan as covered services.

Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.

Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.

Orthoptics. Orthoptics or vision training and any associated supplemental testing.

OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY		In-network Member Cost (after any applicable copay)
Retinal Imaging - at member's option can be performed at time of eye exam		Not more than \$39
Eyeglass lens upgrades When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.	<ul style="list-style-type: none"> ○ Transitions lenses (Adults) \$75 ○ Standard Polycarbonate (Adults) \$40 ○ Tint (Solid and Gradient) \$15 ○ UV Coating \$15 ○ Progressive Lenses¹ <ul style="list-style-type: none"> ○ Standard \$65 ○ Premium Tier 1 \$85 ○ Premium Tier 2 \$95 ○ Premium Tier 3 \$110 ○ Anti-Reflective Coating² <ul style="list-style-type: none"> ○ Standard \$45 ○ Premium Tier 1 \$57 ○ Premium Tier 2 \$68 ○ Other Add-ons and Services 20% off retail price 	
Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	<ul style="list-style-type: none"> ○ Complete Pair 40% off retail price ○ Eyeglass materials purchased separately 20% off retail price 	
Eyewear Accessories	<ul style="list-style-type: none"> ○ Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. 	20% off retail price
Conventional Contact Lenses	<ul style="list-style-type: none"> ○ Discount applies to materials only 	15% off retail price
SOME OF THE ADDITIONAL SAVINGS AVAILABLE THROUGH OUR SPECIAL OFFERS PROGRAM		
1800 CONTACTS After your benefits for the coverage period have been used, you can save on contact lenses with this offer. ³	<ul style="list-style-type: none"> ○ For this and other great offers, login to member services, select discounts, then Vision, Hearing & Dental 	Save \$20 on orders of \$100 or more and get free shipping
Laser vision correction surgery LASIK refractive surgery.	<ul style="list-style-type: none"> ○ For this offer and more like it, login to member services, select discounts, then Vision, Hearing & Dental 	Discount per eye

¹ Please ask your provider for his/her recommendation as well as the progressive brands by tier.

² Please ask your provider for his/her recommendation as well as the coating brands by tier.

³ Discount cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment of services and/or eyewear materials at the time of service.

To Fax: 866-293-7373
 To Email: oonclaims@eyewearspecialoffers.com
 To Mail: Blue View Vision
 Attn: OON Claims
 P.O. Box 8504
 Mason, OH 45040-7111

Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at the number on the back of your ID card.

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. Discounts referenced are not covered benefits under this vision plan and therefore are not included in the member's policy. Frame discounts may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice. This benefit overview is only one piece of your entire enrollment package.

Transitions and the swirl are registered trademarks of Transitions Optical, Inc.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association

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Health, Wellness & Anthem Advantages



Your Anthem plan has so much to offer, you won't want to miss a thing.

Register at [anthem.com](#) today!

Understanding your health plan just got a whole lot easier.

Your health; what's more important? So shouldn't understanding your health plan be just as important? We think so. So we made it easier, with [anthem.com](#).

Once you register, you'll see how [anthem.com](#) makes complex information easy to understand and easy to use. You'll be able to know what's covered and what's not, what your costs will be for procedures, prescription drugs, doctor visits and so much more. Not only that, you can also save money and live better with our online tools that keep you informed, in control and at your healthy best. Take a look at all you can do:

Get an idea of what your costs will be before you go

Did you know that different hospitals and facilities charge different amounts for the same services? Now you can know your cost before you set foot in the hospital by going to [anthem.com](#). By getting an estimate of your costs based on the benefits of your health plan, you can choose a facility that fits your budget.

To learn more visit [anthem.com/costvideo](#).

Look up your claims

Stay on top of your medical claims with this easy online view. You can see the amounts charged to your medical savings account, the amounts paid by your traditional health coverage or how much money you'll need to pay. You may also choose to get emails when claims have been processed, instead of getting notified by regular mail.

To learn how to get information about your claims, go to [anthem.com/guidedtour/claim](#).

Coverage AdvisorSM

A customized comparison of your health care needs and costs

You have a wide range of Anthem health plans to choose from; Coverage Advisor helps you choose the right one for you and your family. It helps you forecast your health care needs and costs and provides you with a clear comparison of benefit plans. If you have a medical savings account, it can also recommend contribution amounts to help cover expenses.

To learn about all the great tools on [anthem.com](#) go to [anthem.com/guidedtour](#)



Your Anthem plan has so much to offer, you won't want to miss a thing. (continued)

Find out which doctors are getting high marks from patients with the Zagat® Health Survey

You can benefit from the experiences of fellow Anthem Blue Cross Blue Shield (Anthem) members to help you find the doctor that's right for you. We've teamed up with Zagat Survey, one of the world's most trusted sources of recommendations by consumers, for consumers. Rate your doctors and also see how others have rated them as well.

Find a Doctor (dentist, pharmacy or hospital)

You can search for doctors, hospitals and other health care facilities quickly online. You can also make your search more specific by choosing a specialty or entering the name of a doctor or facility. And, if you're away from home, you can also search our National Directory.

To search our online Provider Finder:

- Log in at anthem.com
- Select "Find a Doctor" and follow the steps on the screen.

Print a temporary ID card

If you haven't received your permanent ID card yet and want to access health care services now, you can print your temporary ID card online.* Your temporary ID card expires 30 days after its issue date and isn't meant to replace your permanent ID card, which you'll still get in the mail.

*Not all members may be able to request a temporary ID card.

Get members' only discounts on health-related products and services through SpecialOffers

Enjoy discounts such as 20% savings on vitamins and supplements. Save \$20 with a minimum purchase of \$100, plus free shipping and free returns at 1-800 CONTACTS and Glasses.com. Get more from your membership by exploring over 50 discounts available to you.

To learn more about MyHealth Record go to anthem.com/guidedtour/record.

Isn't it time your life got a little easier. If you're not already registered at anthem.com, why not do it now? It's fast, secure and oh so easy!

360° Health® programs

Options. Extras. Support. Helping you improve your health and wellness.

Your health goals and needs are as unique as you are. What's right for one person is not always right for another. Maybe you're managing a health condition. Or maybe you want to stay healthy, eat better or get in shape. Whatever your needs, Anthem gives you a choice of programs to help you meet your personal goals in a way that fits you and helps you live your life to the fullest. From tips and tools to help you learn about preventive care to nurses who can answer your health questions anytime, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

To learn more about 360° Health, go to anthem.com. Look under Health and Wellness. Here are programs we offer:

24/7 NurseLine

Round-the-clock access to health information can really help your peace of mind and your physical well-being. That's why we have registered nurses ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you go to the emergency room or urgent care for this? Where is the nearest one?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, it can help safeguard your health and the health of your family. To learn more visit anthem.com/nurseline_video.

To reach 24/7 NurseLine, just call the customer service number on your ID card and ask to speak to a 24/7 NurseLine representative.

Future Moms

If you are pregnant, we know your goal is to have a safe delivery and a healthy baby. Our Future Moms program helps you make healthy choices while you're pregnant and when you deliver your baby. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues. Our nurses will also call to see how you're doing.
- A helpful book: ***Your Pregnancy Week by Week*** and a maternity care diary.
- Tips and facts to help you handle any unexpected events.
- A questionnaire to see if you're at risk for preterm delivery.
- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks.

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative. To learn more visit anthem.com/futuremoms_video.

360° Health® programs (continued)

ConditionCare

If you or a covered family member has an ongoing illness or health problem, let us help you get more out of life. Our ConditionCare nurses help people of all ages take care of the symptoms of asthma and diabetes. And they work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease. With ConditionCare you'll get the tools you need to help you feel your very best. Our ConditionCare nurses gather information from you and your doctor. Then they create a personalized plan for you.

Information and support are as close as your phone. Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse. To learn more visit anthem.com/conditioncare_video.

ConditionCare support programs

If you or a covered family member has certain types of cancer, vascular or musculoskeletal diseases, or low back pain, ConditionCare may be able to help. The program gives you toll-free, 24-hour access to Nurse Coaches. These coaches are registered nurses who can help you better control your condition and help you follow your doctor's care plan. A team of pharmacists, dietitians and health educators work together to help you. ConditionCare also gives you the information and tools that can help you avoid unnecessary visits to the doctor, hospital stays and time away from work.

Ready to take more control of your health? Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

Here's how it works: We review your health status daily and check to see what medications you're taking. If we see that any of your medicines could interact with each other, we contact your doctor right away. We also keep track of when you need routine tests and checkups. If we notice anything that needs attention, we send you a reminder called a "MyHealth Note". MyHealth Note has a summary of all your recent claims. And from time to time, we give you tips on how to save you money on your medications. To learn more visit anthem.com/myhealthadvantage_video.

ComplexCare

ComplexCare is for our members with more than one health problem or a condition that puts them at risk for needing more care, more often.

With ComplexCare, you have 24/7 toll-free access to nurses who will work one-on-one with you to teach you about taking care of your condition while living the life you like to live. They'll also help you learn about why it's important to go for regular checkups and screenings. The nurses can help you make better choices about your care. They can also help make sure your doctors



360° Health® programs (continued)

all talk to each other about your care and what's best for you. If you qualify for the ComplexCare program, a nurse will contact you.

To learn more, log on to anthem.com or contact the customer service number on your ID card.

LiveHealth Online

Easy, fast doctor visits. All from the comfort of your own computer or mobile device.

Talk to a doctor today, tonight, anytime - 365 days a year. Just enroll at livehealthonline.com or on the free, mobile app.



And Its Affiliate HealthKeepers, Inc.

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LiveHealth[®]
O N L I N E

Now you can get the health care you need without all the hassle.

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.*

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Help at the same cost as your regular doctor visits.
- Private, secure and convenient online visits.

Who are the doctors who use LiveHealth Online?

- U.S. board-certified.
- Average 15 years practicing medicine.
- Mostly primary care physicians.
- Specially trained for online visits.

When can you use LiveHealth Online?

As always, you should call 911 with any emergency. Otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most common uses include:

- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections
- Family health questions

Start a conversation now.

Just enroll for free at livehealthonline.com or on the app, and you're ready to see a doctor.

*As legally permitted in certain states

Download the app now!

[apple.com](https://apple.com/livehealthonline)



play.google.com/store



LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.

Anthem Blue Cross and Blue Shield is the trade name of: Anthem Health Plans of Virginia, Inc. and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross and Blue Shield Association. [®]ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Information You Should Know

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member needs certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, do medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before you get medical care)

We may do a prospective review before a member goes to the hospital or has other types of service or treatment. Here are some types of medical needs that might call for a prospective review:

- A hospital visit
- An outpatient procedure
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans
- Certain types of outpatient therapy, like physical therapy or emotional health counseling
- "Durable medical equipment" (DME), like wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment, a stay in a nursing home, emotional health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.



Managing your care if you need to go to a hospital or get certain medical treatment (continued)

The retrospective or post-service review (done after you get medical care)

We do a retrospective review when you have already had surgery or another type of medical care. When the UM review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically needed.

Case management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preaduthorization

Preaduthorization is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are **based on standards of care in medical policies, clinical guidelines and the terms of your plan**. As these may change, **we review our preauthorization guidelines regularly**. Preaduthorization is also called “precertification,” “prior authorization,” or “pre-approval.”

Here's how getting preauthorization can help you out:

Saving time. Preaduthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who's in our network can help you get the most for your health care dollar.

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor's office will ask for preauthorization for you. Plus, costs are usually lower with in-network doctors.

If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Non-network providers may not do that for you. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

There are times when we may need to do a benefit review for a health care service you plan to receive or have already received. We do this to find out what your plan will cover for that service. During the review, we take a look at the terms, benefits, limitations and exclusions of your particular plan. This means we may check to see if your plan covers the service, if you've already reached a benefit limit for the service, and if you can see a provider outside of the network. We may also review other aspects of your plan.

Your rights and responsibilities as a member

As a member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
 - Your health care plan
 - Any care you get
 - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.



Your rights and responsibilities as a member (continued)

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple ... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross and Blue Shield benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or coinsurance.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which

Important legal information you should take time to read (continued)

you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI – unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.



Important legal information you should take time to read (continued)

- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem, Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure. We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Important legal information you should take time to read

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective Date of this Notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: **Anthem Blue Cross and Blue Shield**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.



Important legal information you should take time to read (continued)

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

Once you're a member, it's easy to get answers to any questions about your plan.

Just call the number on the back of your member identification (ID) card after you get it.



And Its Affiliate HealthKeepers, Inc.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for Anthem HealthKeepers plans. If you have questions, please contact your agent, Group Administrator, or member services: H-INTRO-HK (3/12), H-TOC (1/10), H-SB-POS (3/12), H-SB LUM (3/12), H-WORKS-HK (8/12), H-COVERED-HK (8/12), H-EXCL (3/12), H-CLAIMS-HK (1/12), H-COB (7/10), H-ENR (7/11), H-ENDS (7/10), H-RIGHTS (7/09), H-DEF-HK (3/12), H-EXH-A (10/10), H-INDEX (7/10) Enrollment applications used for Anthem HealthKeepers: 490760 (1/12), 490773 (1/12) This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at P.O. Box 26623 Richmond, VA 23261-0031 Life and Disability products underwritten by Anthem Life Insurance. HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: PP-INTRO (3/12), P-TOC (07/10), P-SB6 (3/12), P-SB7 (3/12) P-COVERED (3/12), P-EXCL (3/12), P-CLAIMS (1/12), P-COB (07/10), P-ENR (10/10), P-ENDS (10/10), P-INFO (1/12), P-RIGHTS (7/09), P-DEF (1/12), P-EXH-A (10/10), P-INDEX (07/10), P-ACC (07/10), GP-1 (7/02), GP-1-TOC, GP-1-ELIG (7/07), GP-1-GEN (1/12) Enrollment applications used for Anthem KeyCare or Lumenos: 490760 (1/12), 490773 (1/12) This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company. Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association.