Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Evidence of Coverage

Randolph Macon College

Plan 10

Take Control of Your Health

Your Health Care Plan

anthem.com

HealthKeepers, Inc.
Anthem HealthKeepers Open Access – Evidence of Coverage

This Evidence of Coverage ("EOC") fully explains *your* health care benefits. Treat it as *you* treat the owner's manual for *your* car - store it in a convenient place and refer to it whenever *you* have questions about *your* health care coverage.

Grandfather disclosure notice

HealthKeepers believes this group health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your health plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Member Services number shown below or to your *group administrator*.

For plans subject to ERISA: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1- 866- 444- 3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

For nonfederal governmental plans: You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Important phone numbers

Member Services

804- 358- 7390
in Richmond
800- 421- 1880
from outside Richmond

How to obtain language assistance

HealthKeepers is committed to communicating with *our* members about their health plan, regardless of their language. HealthKeepers employs a Language Line interpretation service for use by all of *our* Member Services Call Centers. Simply call the Member Services phone number on the back of *your* ID card and a representative will be able to assist *you*. Translation of written materials about *your* benefits can also be requested by contacting Member Services.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If *you* need Spanish- language assistance to understand this document, *you* may request it at no additional cost by calling the customer service number.)

Hours of operation:
Monday- Friday
8:00 a.m to 6:00 p.m.
Saturday
9:00 a.m. to 1:00 p.m.

24/7 NurseLine (Medical Questions and Future Moms)
800- 382- 9625

Key words

There are a few key words *you* will see repeated throughout this *EOC*. We've highlighted them here to eliminate confusion and to make the *EOC* easier to understand. In addition, *we* have included a **Definitions** section on page 65 that lists various words referenced. A defined word will be italicized each time it is used.

Helpful tip: Look for these icons to identify which services are considered *inpatient* and which are *outpatient*.

Inpatient

Outpatient

HMO, we, us, our

Refers to HealthKeepers, Inc.

Subscriber

The eligible employee as defined in the agreement who has elected coverage for himself/herself and his/her dependents (if any) who meet the eligibility requirements of this EOC and enrolls in the HMO, and for whom the premium required by the agreement has been paid to the HMO.

Member

Any subscriber or enrolled dependent.

You, your

Any member.

Outpatient

Care received in a hospital outpatient department, emergency room, professional provider's office, or your home.

Inpatient

Care received while you are a bed patient in the hospital.

Table of contents

page

Summary of benefits 1

How your coverage works 6

Primary Care Physicians 6

Guest Memberships 8

Hospital admissions 11

What is covered 14

What is not covered (Exclusions) 31

Claims and payments 39

What you will pay 39

When you must file a claim 42

When you are covered by more than one health plan 44

Coordination of benefits 44

Changing your coverage 46

Who is eligible for coverage 46

When you may enroll 47

If your family changes 47

After coverage ends 50

Reasons for termination 50

Continuation of coverage (COBRA) 51

Important information about your Health Maintenance Organization coverage 55

Complaint and appeal process 57

Member rights and responsibilities 63

Definitions 65

Exhibit A 70

Experimental/Investigative Criteria 70

Index 72

Special features and programs 74

360° Health Program 74

Vision Program 77

Summary of benefits

This chart is an overview of your benefits for covered services. They are listed in detail beginning on page 14. A list of services that are not covered begins on page 31.

What will I pay?

This chart shows the most you pay for calendar year deductibles and annual copayment limits for covered services in one year of coverage.

	Per member	Per family	Detail Page number
Calendar year deductible	$300	$600	39
The most you will pay per calendar year	$2000	$4000	39

	Copayment	Coinsurance	Detail Page number
Ambulance travel	$100	0%	14
Autism services			14
Applied behavior analysis $35,000 calendar year limit for applied behavior analysis	$0	20%	
All other services for autism	Copayment/coinsurance determined by service rendered		
Clinical trial costs	Copayment/coinsurance determined by service rendered		14
Diabetic supplies, equipment, and education	Copayment/coinsurance determined by service rendered		15
Diagnostic tests For specific conditions or diseases at an emergency room or outpatient facility department. Copayment is waived if services are billed as part of an emergency room visit.			15
Diagnostic x- rays	$0	20%	
Advanced diagnostic imaging services Includes MRI, MRA, MRS, CTA, PET scans, and CT scans	$0	20%	
Dialysis treatments One copayment per calendar month	$40	0%	16

Summary of benefits continued

	Copayment	Coinsurance	Detail Page number
Doctor visits and/or diagnostic tests in the office setting			16
On an outpatient basis			
Primary Care Physician	$20	0%	
Specialty Care Providers	$40	0%	
Advanced diagnostic imaging services Includes MRI, MRA, MRS, CTA, PET scans, and CT scans	$0	20%	
	after calendar year deductible*		
Early intervention services $5000 maximum per member per calendar year. Limit does not apply to physical, speech or occupational therapy services.	Copayment/coinsurance determined by service rendered		16
Emergency room visits Covered only for true emergency services.	$0	20%	16
	after calendar year deductible		
Home care services	$0	20%	17
Hospice care services	$0	0%	17
Hospital services			17
Inpatient admission			
Facility services			
Per stay	$0	20%	
	after calendar year deductible		
Professional provider services	$0	0%	
Infusion services- outpatient services			18
Facility services	$0	20%	
	after calendar year deductible		
Professional provider services	$40	0%	
Ambulatory infusion centers One copayment per calendar month	$40	0%	
Home services One copayment per calendar month	$40	0%	
Lymphedema	Copayment/coinsurance determined by service rendered		18
Maternity			19
Inpatient admission			
Facility services			
Per stay	$0	20%	
	after calendar year deductible		
Professional provider services	$0	0%	
Prenatal, postnatal and delivery See the Claims and payments section of the EOC for additional information on copayments for prenatal and postnatal care	$200	0%	19
Diagnostic tests Maternity related, such as ultrasounds and fetal monitor procedures			19
Facility services	$0	20%	
	after calendar year deductible		
Professional provider services	$40	0%	

	Copayment	Coinsurance	Detail Page number
Medical equipment (durable), devices, appliances, formulas, supplies and medications			
Medical equipment (durable), devices and appliances	$0	20%	19
Medical formulas, supplies and medications	$0	0%	20
	after calendar year deductible*		
Injectable medications Excludes chemotherapy medication and allergy injections/serum	$0	20%	20
Prosthetics	$0	20%	20
	after calendar year deductible		
Mental health and substance abuse			20
Inpatient admission			20
Facility services			
Per stay	$0	20%	
	after calendar year deductible		
Professional provider services	$0	0%	
Outpatient treatment			21
Facility services (includes partial day)	$0	0%	
Facility professional provider services	$0	0%	
Outpatient office visits	$20	0%	21
Skilled nursing facility stays 100- day per stay limit	$0	20%	26
	after calendar year deductible		
Spinal manipulation and manual medical therapy services 30- visits calendar year limit per member. Services must be received by a provider that participates in the American Specialty Health Networks (ASHN).	$25	0%	26
Surgery			26
Inpatient admission			
Facility services			
Per stay	$0	20%	
	after calendar year deductible		
Professional provider services	$0	0%	
Outpatient			
Facility services	$0	20%	
Doctor's office			
Primary Care Physician	$20	0%	
Specialty Care Providers	$40	0%	
Therapy – outpatient services			
Chemotherapy, radiation, cardiac rehabilitation and respiratory			27
Facility services	$0	20%	
	after calendar year deductible		
Professional provider services	$40	0%	

	Copayment	Coinsurance	Detail Page number
Physical, speech, and occupational			27
30 combined visits per member per calendar year for physical and occupational therapy; 30 visits per member per calendar year for speech therapy. Limit does not apply to autism services.			
Facility services	$0	20%	
	after calendar year deductible		
Professional provider services	$25	0%	
Wellness services			
Well child care			
Check- up visits			29
Primary Care Physician	$0	0%	
Screening tests			29
Primary Care Physician	$0	0%	
Immunizations			29
Primary Care Physician	$0	0%	
Preventive care			
Check- up visits			29
Primary Care Physician	$0	0%	
Gynecological exams	$0	0%	29
Mammography screening			29
Facility services	$0	0%	
Professional provider services			
Primary Care Physician	$0	0%	
Specialty Care Providers	$0	0%	
Screening tests			29
Primary Care Physician	$0	0%	
Specialty Care Providers	$0	0%	
Immunizations			29
Primary Care Physician	$0	0%	
Specialty Care Providers	$0	0%	
Colorectal cancer screenings	Copayment/coinsurance determined by service received		29

* calendar year deductible does not apply to wellness services.

	Copayment	Coinsurance	Detail Page number
Prescription drugs			21
Retail pharmacy			21
Covered drugs up to a 30- day supply			
First- tier	$10	0%	
Second- tier	$35	0%	
Third- tier	$55	0%	
Mail order pharmacy			21
Covered drugs up to a 90- day supply			
First- tier	$10	0%	
Second- tier	$70	0%	
Third- tier	$110	0%	

	In- network		Out- of- network	Detail
	Copayment	Coinsurance	Payment allowance	Page number
Routine vision care				30
One eye examination per member each calendar year				
Eye examination	$15	0%	$30	

In order to receive in- network benefits, services should be received from a Blue View Vision Network provider.

For out- of- network care, you will be responsible for the difference between the allowance and the provider's charge.

How your coverage works

Your coverage provides a wide range of health care services. The information contained in this section is designed to help *you* understand how *you* can access *your* benefits. For more specific information on *copayments* and benefit limits, please refer to *your* **Summary of benefits.**

Carry your identification ("ID") card

Your coverage ID card identifies *you* as a *member* and contains important health care coverage information. Carrying *your* card at all times will ensure *you* always have access to this coverage information with *you* when *you* need it. Make sure *you* show *your* ID card to *your* doctor, hospital, pharmacist, or other health care provider so they know you're an Anthem HealthKeepers *member. HMO providers* have agreed to submit claims to *us* on *your* behalf.

Primary Care Physicians ("PCP")

Your PCP will provide *your* primary health care services such as annual physicals and medical tests, oversee care when *you* are ill or injured, and treat any chronic health problems or diseases. *You* should establish a personal and continuous relationship with *your PCP.* Building and maintaining this ongoing relationship is an important part of health care.

Your coverage does not require that *you* obtain a *referral* from *your PCP* to receive care from other *HMO providers.* However, *you* may want to let *your PCP* know about other *HMO providers* that are treating you so that *your PCP* can better oversee *your* health care.

Selecting or changing your Primary Care Physician

You will need to select a *PCP* from a directory of participating providers in order to receive benefits. Each covered family *member* may select a different *PCP.* If *you* do not select a *PCP* upon enrollment or if the *PCP you* previously selected is no longer with the *HMO* network, then *we* may select a *PCP* for *you. Your* ID card will list *your PCP's* name or *your PCP's* group name. If *you* are not satisfied with *your PCP,* then *you* may request another participating *PCP.* If *your PCP* leaves the *HMO* network, *you* will receive a letter notifying *you* of the change in the network. *We* cannot guarantee the continued availability of a particular *HMO provider.*

You may change *your PCP* for a number of reasons; for example, if *you* or *your PCP* moves or if *your* work hours or *your PCP's* hours change. *You* may change *your PCP* by calling Member Services and placing *your* request by telephone. *You* may also change *your PCP* by completing and submitting a change form. The change will be effective the first of the month following *your* telephone call or receipt of *your* change form.

As long as *your* new *PCP* is accepting patients, *your* change request should go through. If the *PCP you* selected is not accepting new patients, *you* may have to select another *PCP.* Requesting a change in *PCP* is limited to once a month.

Helpful tip: *You* may call Member Services for information regarding the qualifications of providers in the *HMO* network. Qualifications include: medical school attended, residency completed and board certification.

Helpful tip: If *you* change *PCPs,* make sure *you* notify *us* before seeing the new *PCP.* A request for a *PCP* change after you've seen the new *PCP* will not be accepted.

The advance approval process

The *HMO* will make coverage decisions on services requiring advance approval within 15 days from the receipt of the request. The *HMO* may extend this period for another 15 days if the *HMO* determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15- day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, the *HMO* will make its decision within 2 working days of its receipt of the medical information needed to process the advance approval request.

For *urgent care claims,* coverage decisions will be completed and we will respond to *you* and *your* provider as soon as possible taking into account *your* medical condition, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, we will ask *you* or *your* provider for the information needed within 24 hours of the receipt of *your* request, and make our decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of our request, we will make our decision within 96 hours from the date of our request.

Once the *HMO* has made a coverage decision on services requiring advance approval, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination,* the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the *HMO's* appeal procedures and applicable time limits;
- in the case of an *urgent care claim,* a description of the expedited appeal and expedited review process applicable to such claims; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you with the internal or external appeals process.

If all or part of a pre- service or urgent care claim was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the *HMO* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the experimental nature of the care, *you* are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

Approvals of care involving an ongoing course of treatment

HMO providers must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If *you* are receiving care from a non-*HMO provider* and need to receive an extension of a previously approved course of treatment, *you* will be required to ask for the extension. *You* should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. *We* will notify *you* of *our* coverage decision within 24 hours of *your* request.

If we make a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an *adverse benefit determination.* If the reduction or termination was not a result of a health plan amendment or health plan termination, we will notify you in advance of the reduction or termination in sufficient time for you to file an internal appeal prior to the reduction or termination.

Non- HMO providers

You should not need to see providers other than *HMO providers* except in emergencies and out- of- area *urgent care situations.* In the event that *you* do receive properly authorized *covered services* from a non- *HMO provider,* then *we* reserve the right to make payment of such *covered services* directly to *you,* the non- *HMO provider,* or any other person responsible for paying the non-*HMO provider's* charge. In the event that payment is made directly to *you, you* have the responsibility to apply this payment to the claim from the non- *HMO provider* . If *you* receive services from a non-*HMO provider* without the proper authorization, *you* will be responsible for the charges for the services.

Terminated providers

The *HMO* network is subject to change as health care providers are added to the network, move, retire, or change their status. When providers decide to leave the network, they become non- participating providers, and services, unless properly authorized, will not be covered.

There are two instances when *members* may continue seeing providers who have left the network:

1. A *member* in the second or third trimester of pregnancy may continue seeing her obstetrician- gynecologist through postpartum care for that delivery.
2. *Members* with life expectancy of six months or less may continue seeing their treating physician.

Guest Memberships

When *you* or any of *your* dependents will be staying temporarily outside of the *service area* for more than 90 days, *you* can request a guest membership to a Blue Cross and Blue Shield affiliated *HMO* in that area. An example of when this service may be utilized is when a dependent *student* attends a school outside of the *service area.* Call a Member Services representative at 866- 823- 5391 to make sure that the area in which *you* or *your* dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated *HMO* Plans. If the area is within the network, *you* will need to complete a guest membership application and *you* will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield *HMO* affiliate where *you* or *your* covered dependents will be staying. Member Services will explain any limitations or restrictions to this benefit. If *you* are staying in an area that is not within the Guest Membership Network, this service will not be available.

The difference between emergency care and urgent care

An *emergency* is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of *urgent care situations* include high fever, vomiting, sprains or minor cuts.

Helpful tip: If *you* cannot contact *your PCP* or are unsure if *your* condition requires *emergency* or *urgent care,* the 24/7 NurseLine is available to assist *you* 7 days a week.

When you need to access health care (within the service area)

- Medical care is available through *your PCP* 7 days a week, 24 hours a day. If *you* need care after regular office hours *you* may contact the on- call *PCP* or the 24/7 NurseLine. For instructions on how to receive care, call *your PCP* or the 24/7 NurseLine at 800- 382- 9625.
- If *your* condition is an *emergency, you* should be taken to the nearest appropriate medical facility.
- *Your* coverage includes benefits for services rendered by providers other than *HMO providers* when the condition treated is an *emergency* as defined in this *EOC.*

When you are away from home (outside the service area) and need to access care

The *HMO* does business only within a certain geographic area in the Commonwealth of Virginia. See **The BlueCard Program** below for *covered services* received outside of Virginia. *Urgent care* and *emergency* services outside the *service area* are provided to help *you* if *you* are injured or become ill while temporarily away from the *service area.* Benefits for these services are limited to care which is required immediately and unexpectedly. Elective care and care required as a result of circumstances which could reasonably have been determined prior to leaving the *service area* are not covered. Benefits for maternity care do not cover normal term delivery outside the *service area,* but do include earlier complications of pregnancy or unexpected delivery occurring outside the *service area.*

If an *emergency* or *urgent care situation* occurs when *you* are temporarily outside the *service area:*

- *you* should obtain care at the nearest medical facility;
- *you* will be responsible for payment of charges at the time of *your visit;* and
- *you* should obtain a copy of the complete itemized bill for filing a claim with the *HMO.* For more information on filing claims see **When you must file a claim** on page 42.

Out- of- Area Services

The *HMO* has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter- Plan Programs." Whenever *you* obtain health care services outside of the *HMO* service area, the claims for these services may be processed through one of these Inter- Plan Programs.

Typically, when accessing care outside the *HMO* service area and the service area of the *HMO* 's corporate parent, *you* will obtain care from health care providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, *you* may obtain care from non- participating health care providers. The *HMO* 's payment practices in both instances are described below.

The *HMO* covers only limited health care services received outside of the *HMO* service area. As used in this "Out- of- Area Covered Health Care Services" include emergency care and urgent care obtained outside the geographic area the *HMO* serves. Any other services will not be covered when processed through any Inter- Plan Programs arrangements. These "other services" must be provided or authorized by *your* primary care physician ("PCP").

The BlueCard® Program

Under the BlueCard® Program, when *you* obtain Out- of- Area Covered Health Care Services within the geographic area served by a Host Blue, the *HMO* will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers.

The BlueCard Program enables *you* to obtain Out- of- Area Covered Health Care Services, as defined above, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Out- of- Area Covered Health Care Services provided to *you*, so there are no claim forms for *you* to fill out. You will be responsible for the copayment amount, as stated in *your* Evidence of Coverage.

Emergency Care Services: If *you* experience a Medical Emergency while traveling outside the *HMO* service area, go to the nearest Emergency or Urgent Care facility.

Whenever *you* access covered health care services outside the *HMO* service area and the claim is processed through the BlueCard Program, the amount *you* pay for covered health care services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for *your* covered services; or
- The negotiated price that the Host Blue makes available to the *HMO*.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to *your* health care provider. Sometimes, it is an estimated price that takes into account special arrangements with *your* health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the *HMO* uses for *your* claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to *your* calculation. If any state laws mandate other liability calculation methods, including a surcharge, *we* would then calculate *your* liability for any covered health care services according to applicable law.

Please refer to the **Claims and payments** section of this EOC for information on **Non- Participating providers and facilities.**

Helpful tip: In the event that *you* travel outside of Virginia and receive *covered services* in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If *you* see a provider who is not part of an exclusive network arrangement, that provider's service(s) will be considered *out- of- network* care, and *you* may be billed the difference between the charge and the allowable charge. *You* may call Member Services or go to www.anthem.com for information regarding such arrangements.

Notification

The *HMO* will participate in coordinating *your* care if *you* are hospitalized as a result of receiving *emergency* services. *You* or a representative on *your* behalf should notify the *HMO* within 48 hours after *you* begin receiving care. **This applies to services received within or outside the *service area.***

Hospital admissions

All non- *emergency* hospital admissions must be arranged by the *member's* admitting *HMO physician* and approved in advance by the *HMO,* except for maternity admissions as specified in the maternity section of this *EOC. We* also reserve the right to determine whether the continuation of any hospital admission is *medically necessary*. For *emergency* admissions, refer to the preceding paragraph **Notification.**

The *HMO* will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. The *HMO* may extend this period for another 15 days if the *HMO* determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15- day period.

In cases where the hospital admission is an urgent care claim, a coverage decision will be completed within 24 hours. *Your* physician will be notified verbally of the coverage decision within this timeframe.

Once a coverage decision has been made regarding *your* hospital admission, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination,* the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the *HMO's* appeal procedures and applicable time limits;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you with the internal or external appeals process.

If all or part of a hospital admission was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the *HMO* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the experimental nature of the care, *you* are entitled to receive upon request, and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to *your* medical condition.

Hospital admissions for covered radical or modified radical mastectomy shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy- assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of *stay* for maternity hospital admissions is determined according to Virginia insurance law. Virginia law does not specify any number of hours that must be approved for a maternity *stay*. However, it requires health insurers and *HMOs* follow the guidelines and standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in determining length of *stay*.

If you changed coverage within the year

Your health plan may include calendar year limitations on *deductibles,* out- of- pocket expenses, or benefits. These limitations may be affected by a change of health plan coverage during the calendar year.

- If *you* change from one employer's health plan to another employer's health plan during the calendar year, new benefit limitations and out- of- pocket amounts will apply as of *your effective date* of coverage under the new employer's health plan. Amounts that may have accumulated toward specific benefits or out- of- pocket amounts under *your* former employer's health plan will not count under *your* new employer's health plan.
- If *you* do not change employers, but move from coverage other than Anthem HealthKeepers coverage (issued by any Anthem- affiliated HMO) to Anthem HealthKeepers coverage during the calendar year, new benefit limitations and out- of- pocket amounts will apply as of the *effective date* of *your* Anthem HealthKeepers coverage. Amounts that may have accumulated toward specific benefits or out- of- pocket amounts under the other coverage will not count under the Anthem HealthKeepers coverage.
- If *you* do not change employers, but move from one Anthem HealthKeepers benefit plan or option to another Anthem HealthKeepers benefit plan or option during the calendar year, any amounts that had accumulated toward the calendar year benefit limitations and out- of- pocket amounts before the change will count under the new Anthem HealthKeepers benefit plan or option for the remainder of the calendar year.

If you have a pre- existing condition

Pre- existing conditions are covered under *your* health plan. *You* do not have to satisfy a waiting period before services for *pre- existing conditions* are covered.

If *your* coverage under this health plan ends or a covered dependent reaches the maximum age limit, the *HMO* will issue a certificate of creditable coverage. The *HMO* will also issue a certificate of creditable coverage upon request, as long as *you* request it within 24 months after coverage ends.

All questions about the pre- existing period and creditable coverage, as well as requests for creditable coverage certificates, should be directed to Member Services at the address or telephone numbers below:

Address:
HealthKeepers, Inc.
Attention: Member Services
P.O. Box 26623
Richmond, VA 23261- 6623

Telephone:
804- 358- 7390
in Richmond
800- 421- 1880
from outside Richmond

What is covered

All benefits are subject to the terms, conditions, definitions, limitations, and exclusions described in this *EOC*. Only *medically necessary covered services* will be provided by the *HMO*. If a service is not considered *medically necessary, you* will be responsible for the charges. *Additionally, we* will only pay the charges incurred by *you* when *you* are actually eligible for the *covered services* received (for example, the premium has been paid by *you* or on *your* behalf).

The following pages describe the benefits available to *you* under this *EOC*.

Ambulance travel

Medically necessary ambulance services will be provided if such services are pre- arranged and authorized by the *HMO*. In an *emergency, HMO* authorization is not required. Air ambulance services are also covered when pre- authorized or in cases of threatened loss of life. In determining whether any ambulance services will be pre- authorized, the *HMO* will take into account whether appropriate, cost- effective care is being provided at the facility where the *member* is located.

Autism services

Your coverage includes certain treatments associated with autism spectrum disorder (ASD) for dependents from age two through age six. Coverage for ASD includes but is not limited to the following:

- diagnosis of autism spectrum disorder;
- treatment of autism spectrum disorder;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

Treatment for ASD includes *applied behavior analysis* when provided or supervised by a board certified behavior analyst, licensed by the Board of Medicine, and billed by such behavior analyst, and the prescribing practitioner is independent of the provider of the *applied behavior analysis*. Coverage is subject to the annual benefit limitation for *applied behavior analysis* shown on the **Summary of benefits.**

Clinical trial costs

Your coverage includes benefits for clinical trial costs. Clinical trial costs means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer. The criteria for these costs is found in Exhibit A.

Dental services

No dental services are provided except for the following:

- *medically necessary* dental services resulting from an accidental dental injury, regardless of the date of such injury. For an injury that occurs on or after *your* effective date of coverage, *you* must seek treatment within 60 days after the injury. *You* must submit a plan of treatment from *your* dentist or oral surgeon for approval by the *HMO* for a dental injury. No approval of a plan of treatment by the *HMO* is required for emergency treatment of a dental injury;
- the cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth;
- the repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face;
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer; or
- covered general anesthesia and hospitalization services for children under the age of 5, *members* who are severely disabled, and *members* who have a medical condition that requires admission to a hospital or *outpatient* surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the *member's* treating physician that such services are required to effectively and safely provide dental care.

☞ **Helpful tip:** The *HMO* provides coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by the *HMO,* are not *covered services.*

Diabetic supplies, equipment, and education

Your coverage provides for medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes and hypodermic needles and syringes when received from an *HMO* pharmacy; and
- *outpatient* self- management training and education performed in- person, including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

Diagnostic tests

Your benefits include coverage for the following procedures when performed by the designated *HMO providers* to diagnose a definite condition or disease because of specific signs and/or symptoms:

- radiology (including mammograms), ultrasound or nuclear medicine;
- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs; and
- advanced diagnostic imaging services (includes magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), magnetic resonance spectroscopy (MRS), positron emission tomography (PET) scan, computed tomography (CT) scan, and computed tomographic angiography (CTA).

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital *stay* is covered under *your* benefits only when:

- *your* medical condition requires that medical skills be constantly available;
- *your* medical condition requires that medical supervision by *your* doctor is constantly available; or

- diagnostic services and equipment are available only as an *inpatient*.

Helpful tip: Medical supplies and other services that may be required and provided in conjunction with a diagnostic test are not considered part of the diagnostic test. Therefore, if a facility or provider bills a separate charge for such services or supplies, benefits for such services or supplies will be provided as described in the **Summary of Benefits** for such services and supplies and not as part of the diagnostic test.

Dialysis

Your coverage provides for dialysis treatment, including hemodialysis and peritoneal dialysis. These are treatments of severe kidney failure or chronic poor functioning of the kidneys.

Doctor visits and services

Call *your PCP* when *you* are in need of health care services. *Your* coverage provides for:

- *visits* to a doctor's office or *your* doctor's *visits* to *your* home;
- *visits* to an urgent care center;
- *visits* to an ambulatory surgery center;
- doctor *visits* in a hospital *outpatient* department or *emergency* room;
- *visits* for shots needed for treatment (for example, allergy shots); and
- interactive *telemedicine services.*

Early intervention services

Your coverage includes benefits for early intervention services for covered dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be *medically necessary* by the Department and designed to help an individual attain or retain the capability to function age- appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not *medically necessary*.

Emergency room care

Your benefits include coverage for *emergency* room *visits,* services, and supplies necessary for the treatment of an *emergency* as defined on page 65 of this *EOC*.

Home care services

When authorized by the *HMO, we* cover treatment provided in *your* home on a part- time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat *your* condition. To ensure benefits, *your* doctor must provide a description of the treatment *you* will receive at home. *Your* coverage includes the following home health services:

- visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- physical, speech, and occupational therapy (services provided as part of home health are not subject to separate visit limits for therapy services).

These services are only covered when *your* condition confines *you* to *your* home at all times except for brief absences.

Hospice care services

Hospice care will be covered, for *members* diagnosed with a terminal illness with a life expectancy of six months or less. *Covered services* include the following:

- skilled nursing care, including IV therapy services;
- drugs and other *outpatient* prescription medications for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- short- term *inpatient* care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non- acute *inpatient* care for the *member* in order to provide the *member's* primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non- routine and occasional basis and may not be provided for more than five days every 90 days;
- physical, speech, or occupational therapy (services provided as part of hospice care are not subject to separate visit limits for therapy services);
- *durable medical equipment;*
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling with respect to the *member's* care and death; and
- bereavement counseling for immediate family members both before and after the *member's* death.

Hospital services

Your coverage provides benefits for the hospital and doctors' services when *you* are treated on an *outpatient* basis, or when *you* are an *inpatient* because of illness, injury, or pregnancy. (See **Maternity** on page 19 for an additional discussion of pregnancy benefits.) *Your* benefits include coverage for *medically necessary* care in a semi- private room or intensive or special care unit. This includes *your* bed, meals, special diets, and general nursing services.

In addition to *your* semi- private room, general nursing services and meals, *your* coverage includes *maximum allowed amounts* for *medically necessary* services and supplies furnished by the hospital when prescribed by *HMO physicians.*

While *you* are an *inpatient* in the hospital, *you* have coverage for the *medically necessary* services rendered by *HMO physicians* and other *HMO providers.*

Helpful tip: All non- *emergency inpatient* hospital stays must be approved in advance, except hospital stays for vaginal or cesarean deliveries without complications.

Private room

Your inpatient hospital benefits include a *stay* in a semi- private room unless a private room is approved in advance by the *HMO. We* will cover the private room charge if *you* need a private room because *you* have a highly contagious condition or are at greater risk of contracting an infectious disease because of *your* medical condition. Otherwise, *your inpatient* benefits will cover the hospital's charges for a semi- private room. If *you* choose to occupy a private room, *you* will be responsible for paying the daily differences between the semi- private and private room rates in addition to *your copayment* and *coinsurance* (if any).

Individual case management

In addition to the *covered services* specified in this *EOC,* the *HMO* may elect to offer benefits for an alternative treatment plan plus services on a case by case basis. The *HMO* shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that the alternative services are *medically necessary* and cost- effective. Nothing shall prevent a *member* from appealing the *HMO's* decision that an alternative service is *medically necessary*. The total benefits paid for such services will not exceed the maximum benefits to which the *member* would otherwise be entitled under this *EOC* in the absence of alternative benefits. If the *HMO* elects to provide alternative benefits for a *member* in one instance, it shall not obligate the *HMO* to provide the same or similar benefits for any *member* in any other instance, nor shall it be construed as a waiver of the *HMO's* right to administer this *EOC* in strict accordance with its express terms.

Also, from time to time the *HMO* may offer a *member* and/or their *HMO provider* information and resources related to disease management and wellness initiatives. These services may be in conjunction with the *member's* medical condition or with therapies that the *member* receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

Infusion services

When authorized by the *HMO, we* cover infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

Helpful tip: Infusion services may be received at multiple sites of service, including facilities, professional provider offices, ambulatory infusion centers and from home infusion providers. Benefits may vary by place of service, and where *you* choose to receive *covered services* may result in a difference in *your copayment* and/or *coinsurance*. Please see the Infusion services section on the Summary of benefits for a description of the benefits by place of service.

Lymphedema

Your coverage includes benefits for expenses incurred in connection with the treatment of **lymphedema.**

Maternity

Prenatal and newborn care

If the *subscriber* or *subscriber's* dependent becomes pregnant, *your HMO* provides several coverage features. Maternity care, maternity- related checkups, and delivery of the baby in the hospital are covered.

Your benefits include:

- home *setting* covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital *stay;*
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- *home care services* for postnatal care;
- circumcision of a covered male dependent;
- services for interruption of pregnancy;
- use of the delivery room and care for normal deliveries; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

Future Moms

A *subscriber* or *subscriber's* covered dependent is eligible to participate in Future Moms. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A Future Moms consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full- term delivery. As soon as pregnancy is confirmed, sign up for the program by calling 800- 828- 5891. *You* will receive:

- a kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- a risk appraisal to identify signs of premature labor; and
- after delivery, a birth kit and child care book.

Helpful tip: See **If your family changes** on page 47 for details on when and how to enroll a newborn.

Medical equipment (durable)

We cover the rental (or purchase if that would be less expensive) of *medical equipment (durable)* when obtained from an *HMO medical equipment (durable)* provider. Also covered are maintenance and necessary repairs of *medical equipment (durable)* except when damage is due to neglect.

Examples of covered *medical equipment (durable)* include:

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

Medical devices and appliances

We cover the cost of fitting, adjustment, and repair of the following items when prescribed for *activities of daily living:*

Examples of covered medical devices include:

- orthopedic braces;
- leg braces, including attached or built- up shoes attached to the leg brace;
- molded, therapeutic shoes for diabetics with peripheral vascular disease;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints.

Medical formulas

We cover special medical formulas which are the primary source of nutrition for *members* with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Medical supplies and medications

Your coverage includes benefits for medical supplies and medications. Examples of medical supplies include:

- hypodermic needles and syringes;
- allergy serum;
- oxygen and equipment (respirators) for its administration; and
- non- injectable prescription medications provided by *your* doctor.

Injectable medications

Your coverage includes benefits for self- administered injectable medications obtained through an retail pharmacy or administered by an *HMO provider.*

Prosthetic devices and components

Your coverage includes benefits for prosthetic devices. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot, or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

Mental health or substance abuse treatment

Accessing *your* mental health services and substance abuse services (treatment of alcohol or drug dependency) is easy. In fact, *you* have a dedicated department available to *you* simply by calling 800- 991- 6045. These services require preauthorization from the *HMO. You* can select any mental health and substance abuse provider listed in *your HMO provider* directory. Or if *you* are unsure of which provider to see, call 800- 991- 6045 and the representative will be able to match *you* with a provider who seems best suited to meet *your* needs.

Inpatient treatment
You have coverage for *inpatient* care for mental health services and substance abuse services. *Your* coverage includes individual psychotherapy, group psychotherapy, psychological testing, counseling with family *members* to assist with the patient's diagnosis and treatment, and convulsive therapy treatment. Please note that *inpatient* services for substance abuse must be provided in a hospital or substance abuse treatment *facility* which is licensed to provide a continuous, structured, 24- hour- a- day program of drug or alcohol treatment and rehabilitation including 24- hour- a- day nursing care.

Partial day services
You also have coverage for partial day mental health services and substance abuse services. A partial day program must be licensed or approved by the state and must include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance abuse, or an intensive *outpatient* program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.

Outpatient treatment
Your coverage includes treatment for *outpatient mental health and substance abuse services.*

Medication Management
Visits to *your HMO physician* to make sure that medication *you* are taking for a mental health or substance abuse problem is working and the dosage is right for *you* are covered.

Obstetrician- gynecologist physician services

All female *members* may receive services from an obstetrician- gynecologist who is an *HMO physician* for the care of or related to the female reproductive system and breasts. The obstetrician- gynecologist must obtain authorization from the *HMO* for *inpatient* hospital services and *outpatient* surgery.

Prescription drugs

Your benefits cover *prescription drugs* if received through a pharmacy, a doctor's office, or a hospital.

If *you* receive non- injectable *prescription drugs* from *your* doctor, they will be covered as other medical services or supplies. If *you* receive *prescription drugs* from *your* hospital, they will be covered as a hospital service.

Your coverage includes prescription and over- the- counter drugs used to assist with smoking cessation. For over- the- counter drug coverage, *you* will need to purchase through a pharmacy with a prescription order from *your* doctor.

Your prescription drug card benefits
Your prescription drug card benefits cover prescriptions obtained from a pharmacist. *You* may receive up to a 30- day supply of medicine for an original prescription or refill for up to one year. *Your* coverage also includes benefits for compound drugs, injectable insulin, syringes and needles, lancets, test strips, and home glucose blood monitors. Simply choose a pharmacy in the retail pharmacy network and show *your* ID card to receive benefits.

To find a retail pharmacy *you* should:

- refer to *your* health plan's directory of network providers at www.anthem.com which lists participating pharmacies;
- check with *your* local pharmacy to see if they participate in the retail pharmacy network; or
- call Member Services.

Pharmacies in the retail pharmacy network, available nationwide, will automatically file claims for *you* and charge *you* only the required *copayment, coinsurance* and/or *deductible* (if any) amounts under *your* benefit program for covered prescriptions.

From time to time *we* may initiate various programs to encourage *members* to utilize more cost- effective or clinically- effective drugs including, but not limited to, generic drugs, mail order drugs, over- the- counter (OTC) drugs, or preferred products. Such programs may involve reducing or waiving copayments or coinsurance for certain drugs or preferred products for a limited period of time.

Helpful tip: *Copayments, coinsurance* and/or *deductible* (if any) amounts for *outpatient prescription drugs* do not apply to *your* annual calendar year limit.

You must have used 75% of *your* prescription before it can be refilled. However, in the following circumstances, *you* can obtain an additional 30- day supply from *your* pharmacist:

- you've lost *your* medication;
- *your* medication was stolen; or
- *your* physician increases the amount of *your* dosage.

We and our pharmacy benefits manager (PBM) receive financial credits from drug manufacturers based on the total volume of claims processed for their products utilized by *our members.* These credits are used to help stabilize rates. Reimbursements to pharmacies are not affected by these credits.

First- tier, second- tier, and third- tier drugs

The amount *you* will pay for a *prescription drug* depends on whether the drug *you* receive is a *first- tier, second- tier,* or *third- tier drug.* Refer to *your* **Summary of benefits** to determine *your copayment, coinsurance* and *deductible* (if any) amounts. *Prescription drugs* will always be dispensed as ordered by *your* physician. *You* may request, or *your* physician may order, the brand name drug. If your physician orders a brand name drug, *you* will be responsible for the appropriate second- tier or third- tier *copayment* . However if *you* request a brand name drug that your physician has not ordered and a generic drug is available, *you* will be responsible for the difference in the *maximum allowed amount* between the generic and brand name drug, in addition to *your* generic *copayment.* By law, generic and brand name drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. *We* reserve the right, in *our* sole discretion, to remove certain higher cost generic drugs from this policy.

Your prescription drug benefit includes the Half- Tablet Program. This program will allow *members* to pay a reduced cost share on selected "once daily dosage" medications. The Half- Tablet Program allows *you* to obtain a 30- day supply (15 tablets) of the higher strength medication when written by the physician to take "½ tablet daily" of those medications on the approved list. The National Pharmacy and Therapeutics (P&T) Committee will determine additions and deletions to the approved list. The Half- Tablet Program is strictly voluntary and *your* decision to participate should follow consultation with and the concurrence of *your* physician. To obtain a list of the products available on this program contact 800- 962- 8192.

The *HMO* also limits coverage of *prescription drugs* to only those listed on the Anthem formulary. Most *prescription drugs* are listed on this formulary; however, certain *prescription drugs* with clinically equivalent alternatives may be excluded. *We* may add or delete *prescription drugs* from the formulary from time to time. A description of the *prescription drugs* that are listed on the formulary is available upon request and at www.anthem.com. There are two exceptions to the formulary requirement:

- *You* may obtain coverage without additional cost sharing beyond that which is required of formulary *prescription drugs* for a non- formulary drug if *we* determine, after consultation with the prescribing physician, that the formulary drugs are inappropriate therapy for *your* condition.
- *You* may obtain coverage without additional cost sharing beyond that which is required of formulary *prescription drugs* for a non- formulary drug if:
    - *you* have been taking or using the non- formulary *prescription drug* for at least six months prior to its exclusion from the formulary; and
    - the prescribing physician determines that either the formulary drugs are inappropriate therapy for *your* condition, or that changing drug therapy presents a significant health risk.

You may use the prior authorization process, described on page 25, to request a non- formulary drug and *we* will act on *your* request within one business day of its receipt.

We have established a National P&T Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining whether a drug will be included in the formulary; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross- branded initiatives, drug profiling initiatives and the like.

The determinations of tier assignments and formulary inclusion are made by the *HMO* based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over- the- counter alternatives; generic availability, the degree of utilization of one drug over another in the patient population; and where appropriate, certain clinical economic factors.

We retain the right at our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another tier.

Services of non- participating pharmacies

Notwithstanding any provision in this *EOC* to the contrary, *you* have coverage for *outpatient* prescription drug services provided to *you* by a non- *HMO* pharmacy that has previously notified the *HMO* of its *agreement* to accept reimbursement for its services at rates applicable to *HMO* pharmacies including any applicable *copayment, coinsurance* and/or *deductible* (if any) amounts as payment in full to the same extent as coverage for *outpatient* prescription drug services provided to *you* by an *HMO provider*. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy *agreement* with the *HMO* or its designee within thirty days of being requested to do so in writing by the *HMO,* unless and until the pharmacy executes and delivers the agreement.

If *you* have a prescription filled at a non- participating pharmacy, *you* must complete and submit a claim form. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. If *you* have questions or need a claim form, call Member Services or *visit our* website at www.anthem.com.

When you may need to file a claim

You may need to file *your* own claim if:

- *your* prescription is filled by a non- participating pharmacy;
- *you* need to have a prescription filled before *you* receive *your* card; or
- *you* have a prescription that requires special prior approval, but *you* need the prescription filled immediately.

Contact Member Services if *you* need a Direct Member Reimbursement Claim Form or if *you* have any questions about *your* drug program or related procedures.

To file a claim, follow these 3 steps:

1. complete the Direct Member Reimbursement Claim Form. If possible, ask the pharmacist to complete the pharmacy section of the form and sign;

2. pay for the prescription; and

3. mail *your* claim form to the address on the back of the form within 15 months of purchasing the prescription.

Maintenance medications

You may also purchase covered *maintenance medications* through the mail from the mail order pharmacy network, and *your* prescription will be delivered directly to *your* home. To receive *your* maintenance medicine prescription by mail, follow these 3 steps:

1. Ask *your* doctor to prescribe a 90- day supply of *your* maintenance medicine plus refills. If *you* need the medicine immediately, ask *your* doctor for two prescriptions: one to be filled right away and another to send to the mail order pharmacy.

2. Complete the Patient Profile Questionnaire which is enclosed within the envelope from the mail order pharmacy. This is needed for *your* first order only.

3. Mail *your* written prescription, and a check to cover the amount of *your copayment, coinsurance* and/or *deductible* (if any) to the mail order pharmacy.

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

You will receive refill forms and a notice that shows the number of refills *your* doctor ordered in the package with *your* drugs. To order refills, *you* must use 75% of *your* current prescription. Mail the refill notice and the appropriate *copayment, coinsurance* and/or *deductible* (if any) amounts to the mail order pharmacy in the envelope provided.

Helpful tip: If *you* have questions concerning the mail order program, *you* can call Member Services at 800- 421- 1880.

Helpful tip: *We* suggest that *you* order *your* refill two weeks before running out of *your* medication.

Specialty medications under your prescription drug card benefit

Members who use certain covered specialty drugs must purchase them through the specialty pharmacy network. *You* may obtain a list of specialty drugs available through the specialty pharmacy by contacting Member Services or online at www.anthem.com. These specialty drugs will be covered only when obtained through this network. Specialty drugs are high- cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. The specialty pharmacy will fill both retail and mail order prescriptions, although the ability to provide a 90- day supply of a specialty drug may be limited by the storage requirements of that particular drug.

The specialty pharmacy provides dedicated patient care coordinators to help *you* manage *your* condition and toll- free twenty- four hour access to nurses and registered pharmacists to answer questions regarding *your* medications. *You* or *your* doctor can order *your* specialty medication direct from the specialty pharmacy by simply calling 800- 870- 6419. *You* will be assigned a patient care coordinator who will work with *you* and *your* physician to obtain prior authorization and to coordinate the shipping of *your* medication directly to *you* or *your* physician's office. *Your* patient care coordinator will also contact *you* directly when it is time to refill *your* prescription.

Prior authorization

We require prior review of selected formulary drugs as well as non- formulary drugs before payment is authorized; for example, growth hormones. *Your* doctor has a list of drugs that require special approval. *You* may obtain a copy of this list by simply contacting Member Services or from the Internet at www.anthem.com. This list is periodically modified. *Your* doctor or pharmacist should submit a request that includes the drug name, quantity per day and strength, period of time the drug is to be administered, medical condition for which the drug is being prescribed, the patient's name, ID number, date of birth, and relationship to the employee. The request, along with applicable medical records, may be submitted in writing, by telephone, or by fax to:

Drug Prior Authorization
P.O. Box 746000
Cincinnati, OH 45274

Telephone:
800- 338- 6180
Fax:
800- 601- 4829

You will receive a written notice when a prescription is denied for coverage. *Your* physician will be notified of both approval and denial decisions.

The *HMO* cannot deny *prescription drugs* (or *inpatient* or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Skilled nursing facility stays

The following items and services will be provided to *you* as an *inpatient* in a skilled nursing bed of an *HMO provider* skilled nursing facility or in a skilled nursing bed in an *HMO provider* hospital:

- room and board in semi- private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other *medically necessary* services and supplies.

Your inpatient skilled nursing facility benefits include a stay in a semi- private room unless a private room is approved in advance by the *HMO*. *We* will cover the private room charge if *you* need a private room because *you* have a highly contagious condition or are at greater risk of contracting an infectious disease because of *your* medical condition. Otherwise, *your inpatient* benefits would cover the skilled nursing facility's charges for a semi- private room. If *you* choose to occupy a private room, *you* will be responsible for paying the daily differences between the semi- private and private room rates in addition to *your copayment* and *coinsurance* (if any).

Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care.

Spinal manipulation and manual medical therapy services

Your coverage includes spinal manipulation and manual medical therapy services when performed by a provider within the American Specialty Health Networks (ASHN). *Covered services* include examination, re- examination, manipulation, conjunctive therapy, radiology, durable medical equipment, and laboratory tests related to the delivery of these services.

To receive care, please *visit* our website at www.anthem.com, or contact ASHN directly for a list of ASHN providers. Then, simply contact a participating ASHN provider to make an appointment. The ASHN provider is responsible for obtaining authorization prior to providing care.

Questions concerning ASHN providers may be directed to ASHN's network department at 800- 972- 4226. Questions concerning coverage may be directed to ASHN's customer service department at 800- 678- 9133. Both departments are open 9:00 a.m. to midnight, Eastern Standard Time, Monday- Friday, and noon to 8:00 p.m. Eastern Standard Time, Saturday- Sunday.

Surgery

General surgery

Your coverage includes benefits for surgery services when approved in advance by the *HMO* and when treatment is received at an *inpatient, outpatient,* or ambulatory surgery facility, or doctor's office. *We* will not pay separately for pre- and post- operative services.

Oral Surgery

Your benefits include oral surgery for:

- surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth or their supporting structures;
- treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed *medically necessary* to attain functional capacity of the affected part.

Organ and tissue transplants, transfusions

We cover organ and tissue transplants and transfusions. When a covered human organ or tissue transplant is provided from a living donor to a *member,* both the recipient and the donor may receive the benefits of this *EOC.*

Helpful tip: Certain organ or tissue transplants are considered *experimental/investigative* or not *medically necessary*. Coverage for organ and tissue transplants is determined through the pre- authorization process.

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.

Reconstructive breast surgery

Mastectomy, or the surgical removal of all or part of the breast, is a covered service. Also covered are:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the *member*.

Therapy

Cardiac rehabilitation therapy

Your coverage includes benefits for cardiac rehabilitation which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy

Your coverage includes benefits for the treatment of disease by chemical or biological antineoplastic agents.

Physical, occupational and speech therapy

Your coverage includes benefits for short- term physical, occupational, and speech therapy when the treatment is *medically necessary* for *your* condition. In the judgment of the *HMO,* short- term rehabilitative therapy services can be expected to result in significant improvement of *your* condition within 90 consecutive days of beginning *outpatient* treatment. Refer to *your* **Summary of benefits** for limitations, *copayment* and *coinsurance* amounts.

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

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

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

Helpful tip: Long term therapy or rehabilitative care is excluded unless otherwise specified in this *EOC* as covered under Early Intervention Services.

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

Respiratory therapy
Your benefits include respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Vision correction after surgery or accident

In situations such as those defined below, *your* coverage includes the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
    - contact lenses are used for the treatment of infantile glaucoma;
    - corneal or scleral lenses are prescribed in connection with keratoconus;
    - scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
    - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Wellness services

Your coverage provides for preventive services for children and adults, including screenings, immunizations and other services to detect medical conditions in advance. The preventive services listed below are covered. The list has been developed taking into account the recommendations of the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and for childhood immunizations, as prescribed by the Commissioner of Health.

Well child care

Well child benefits include coverage for check- ups, screenings, and immunizations for *your* child through age 17. Covered services include the following:

- complete physical examinations, developmental assessment and guidance;
- certain laboratory and screening tests, including screening for lead exposure and hearing and vision tests; and
- immunizations such as diphtheria, tetanus, pertussis (DTP), polio, measles, mumps, rubella (MMR), hemophilus influenza b (Hib) vaccine, hepatitis B, varicella virus (chicken pox) vaccine, pneumococcal conjugate vaccine, influenza, rotavirus, human papilloma virus (HPV), and other immunizations as may be prescribed by the Commissioner of Health.

Helpful tip: These benefits are for well children. Treatment of an illness or *emergency* is covered according to the terms described for specific conditions or treatments.

Preventive care

Preventive care provides benefits for covered members age 18 and older that allow *you* and *your* doctor to choose those services that *you* need most. In addition to the office visits that accompany these services, the following screening and immunization services are included:

- eye chart vision screening (full vision exams are not included unless *your HMO* includes a routine vision benefit);
- hearing screening;
- cholesterol and lipid level screening;
- blood glucose test to screen for Type II diabetes;
- prostate cancer screenings including digital rectal exam and PSA test;
- pelvic exam, Pap test (performed by any FDA- approved gynecologic cytology screening technologies), and contraceptive management for females;
- breast exam and mammography screening;
- screening for sexually transmitted diseases;
- HIV test;
- bone density test to screen for osteoporosis;
- colorectal cancer screening including fecal occult blood test, barium enema; flexible sigmoidoscopy, and screening colonoscopy;
- routine blood and urine screenings;
- immunizations in accordance with the recommendations of the previously mentioned organizations such as hepatitis A; hepatitis B; tetanus, diptheria (Td); varicella (chicken pox); influenza (flu shot); pneumococcal conjugate (pneumonia); human papilloma virus (HPV); measles, mumps, rubella (MMR); meningococcal polysaccharide; and herpes zoster (shingles).

Helpful tip: Sometimes 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. Also, if you have a personal or family history of a particular condition, certain screenings may not be considered preventive services, as covered preventive care services take into account the age and health risk of the covered person. Either of these situations may result in a possible difference in *your copayment* and/or *coinsurance.* Please see the **Diagnostic tests** and **Surgery** sections on the **Summary of benefits** and earlier in this section for a complete description of these benefits.

Routine vision care

Your coverage includes benefits for one eye exam each calendar year. In order to receive in- plan benefits, *you* will need to receive vision care from a Blue View Vision participating provider. If *you* elect to receive care from a provider who does not participate in the Blue View Vision Network, *you* will receive *out- of- plan benefits.* For additional information about benefits or a participating location, please consult *your* provider directory or contact Member Services.

When you must file a vision claim

Network providers file claims on *your* behalf. *You* may have to file a claim if *you* receive care from a provider that does not participate in the Blue View Vision Network. To file a claim follow these 3 steps:

1. Call 800- 421- 1880 to order a claim form.
2. Complete and sign the claim form. Attach all itemized bills for *covered services.* Each itemized bill must contain the following:
    - name and address of the person or organization providing services or supplies;
    - name of the patient receiving services or supplies;
    - date services or supplies were provided;
    - the charge for each type of service or supply; and
    - a description of the services or supplies received.
3. Send the completed claim form and itemized bill(s) to:

Blue View Vision, OON Claims
P.O. Box 8504
Mason, OH 45040- 7111

What is not covered (Exclusions)

This list of services and supplies are excluded from coverage under this *EOC.* They will not be covered in any case.

A

Your coverage does not include benefits for **acupuncture.**

Your coverage does not include benefits for services received which are not **authorized in advance by the *HMO* and pre- arranged by *your PCP,*** unless otherwise specified in this *EOC.*

B

Your coverage does not include benefits for **biofeedback therapy.**

C

Your coverage does not include benefits for over- the- counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, diapers, and ice bags.

Your coverage does not include benefits for, or related to, **cosmetic surgery or procedures,** including complications that directly 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. The *HMO* will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for the following **dental** or oral surgery services:

- 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;

- treatment of natural teeth due to accidental injury occurring on or after *your* effective date of coverage, unless treatment was sought within 60 days after the accidental injury and *you* submitted a treatment plan to the *HMO* for prior approval. No approval of a plan of treatment by the *HMO* is required for emergency treatment of a dental injury;
- 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 on page 15 of this *EOC*.

Your coverage does not include benefits for **donor** searches for organ or tissue transplants, including compatibility testing of potential donors who are not immediate blood- related family *members* (parent, child, sibling).

E

Your coverage does not include benefits for services or supplies primarily for **educational**, vocational, or self management/training purposes, except as otherwise specified in this *EOC*.

Your coverage does not include benefits for ***experimental/investigative*** procedures as well as services related to or complications that directly result from such procedures except for clinical trials for cancer. The criteria for deciding whether a service is *experimental/investigative* or a clinical trial cost for cancer as specified in **Exhibit A** on page 70.

F

Your coverage does not include benefits for the following **family planning** services:

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

Your coverage does not include benefits for services for palliative or cosmetic **foot** care are including:

- 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 (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except as treatment for patients with diabetes or vascular disease);
- care of toenails (except as treatment for patients with diabetes or vascular disease);
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

H

Your coverage does not include benefits for **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.

Your coverage does not include benefits for **hearing aids** or for examinations to prescribe or fit hearing aids, unless otherwise specified in the *EOC*.

Your coverage does not include benefits for the following ***home care services:***

- homemaker services (except as rendered as part of hospice care);
- maintenance therapy;
- food and home delivered meals; or
- custodial care and services.

Your coverage does not include benefits for the following **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;* or
- a private room unless it is *medically necessary* and approved by the *HMO*.

I

Your coverage does not include benefits for **immunizations** required for travel and work, unless such services are received as part of the covered preventive care services as defined on pages 29 of this *EOC*.

M

Your coverage does not include benefits for **medical equipment (durable), appliances, devices, and supplies** that have both a non- therapeutic and therapeutic use. These include but are not limited to:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens, bed boards;
- 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; or
- repair or replacement of equipment *you* lose or damage through neglect.

Your coverage does not include benefits for ***medical equipment (durable)*** that is not appropriate for use in the home.

Your coverage does not include benefits for services or supplies deemed not ***medically necessary*** by the *HMO* at its sole discretion. Notwithstanding this exclusion, all wellness services and hospice care services described in this *EOC* are covered. This exclusion shall not apply to services *you* receive on any day of *inpatient* care that is determined by the *HMO* 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 such as reviewing patient status, test results, and patient medical records. *Inpatient* evaluation and management *visits* do not include surgical, diagnostic, or therapeutic services performed by *your* admitting or attending physician. Also, this exclusion shall not apply to the services rendered by a pathologist, radiologist, or anesthesiologist 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.

Nothing in this exclusion shall prevent a *member* from appealing the *HMO's* decision that a service is not *medically necessary.*

Your coverage does not include benefits for the following **mental health services and substance abuse services:**

- *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; or
- remedial or special education services.

N

Your coverage does not include benefits for services administered by **non- *HMO providers,*** except for emergencies or when authorized, in advance by the *HMO Medical Director*.

Your coverage does not include benefits for **nutrition** counseling and related services, except when provided as part of diabetes education.

Your coverage does not include benefits for **nutritional and/or dietary supplements** , except as provided under this *EOC* 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.

O

Your coverage does not include benefits for services and supplies related to **obesity** or services 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.

Your coverage does not include benefits for **organ or tissue transplants,** including complications caused by them, except as outlined on page 27 of this *EOC*.

P

Your coverage does not include benefits for **paternity testing.**

Your **prescription drug** benefit does not cover:

- over- the- counter drugs, except as specified on page 21 of this EOC;
- any per unit, per month quantity over the specified limit;
- drugs used mainly for cosmetic purposes;
- drugs that are experimental, investigational, or not approved by the FDA (see page 70);
- cost of medicine that exceeds the *maximum allowed amount* for that prescription;
- drugs for weight loss;
- 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;*
- any refill dispensed after one year from the date of the original prescription order;
- infertility medications;
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or
- medicine furnished by any other drug or medical service.

R

Your coverage does not include benefits for 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 services.

S

Your coverage does not include benefits for **services, supplies, or devices** if they are:

- not listed as covered under this *EOC;*
- not prescribed, performed, or directed by a provider licensed to do so;
- received before the *effective date* or after a *member's* coverage ends; or
- telephone consultations, charges for not keeping appointments, charges for completing claim forms, or other such charges.

Your coverage does not include benefits for **services or supplies** if they are provided or available to a *member:*

- 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 benefit plans offered to either civilian employees or retired civilian employees of the federal or state government.
- 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 *EOC* have been paid.

This exclusion applies whether or not the *member* waives his or her rights under these laws, amendments, programs or terms of employment. However, the *HMO* will provide the *covered services* specified in this *EOC* when benefits under these programs have been exhausted.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which *you* would not have been charged if *you* did not have health care coverage.

Your coverage does not include benefits for:

- amounts above the *maximum allowed amount* for a service;
- penile implants; or
- neurofeedback and related diagnostic tests.

Your coverage does not include benefits for services for **sex transformation or sexual dysfunction.** This includes medical and mental health services.

Your coverage does not include benefits for the following **skilled nursing facility** stays:

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

Your coverage does not include benefits for **smoking cessation** programs not affiliated with us.

Your coverage does not include benefits for the following **spinal manipulation and manual medical therapy services:**

- any treatment or service not authorized by ASHN;
- any treatment or service not provided by an ASHN provider;
- services for examination and/or treatment of strictly non- neuromusculoskeletal 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 or in the research state;
- diagnostic scanning, including magnetic resonance imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography;
- educational programs, non- medical self- care or self- help, or any self- help physical exercise training, or any related diagnostic testing;
- air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; or
- vitamins, minerals, nutritional supplements, or any other similar type products.

T

Your coverage does not include benefits for the following **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 from birth to age three who qualify for Early Intervention services;
- group speech therapy;
- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

Your coverage does not include benefits for non- interactive **telemedicine services.** Non- interactive telemedicine services include an audio- only telephone conversation, electronic mail message, or facsimile transmission.

V

Your coverage does not include benefits for the following **vision** services:

- routine vision care and materials, except as outlined on page 29 of this *EOC,* under Wellness services and the following page under Routine vision care;
- vision services or supplies unless needed due to eye surgery or accidental injury;
- 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 accompanying frames of any type;
- any non- prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no reflective power;
- any lost or broken lenses or frames;
- any blended lenses (no lines), oversize lenses, polycarbonate lenses (for dependents over the age of 19 and adults), progressive multifocal lenses, photochromatic lenses, Transitions lenses (for dependents over the age of 19 and adults), tinted lenses, coated lenses, anti- reflective coating, cosmetic lenses or processes and UV- protected lenses;
- any frame in which the manufacturer has imposed a no discount policy;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; or
- any other vision services not specifically listed as covered.

W

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

Your coverage does not include benefits for 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. Services will not be covered if *you* could have received benefits for the injury or disease if *you* had complied with applicable laws and regulations. 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 *member* reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

Claims and payments

We consider the charge to be incurred on the date a service is provided. This is important because *you* must be actively enrolled on the date the service is provided. Various limits will be described in the **Summary of benefits** and this section of the *EOC*.

Calendar year deductible

Your benefits include a calendar year *deductible* for *covered services*. Before *we* will make payments for certain *covered services, you* must first satisfy the *deductible*. See the **Summary of benefits** section of this *EOC* for the amount of *your* calendar year *deductible* and applicable services.

Covered services received during the last three months of the calendar year that applied to a *covered person's deductible,* may also apply to the *deductible* required for the following calendar year.

What you will pay

Copayments and *coinsurance* (if any) for certain *covered services* are outlined in the **Summary of benefits.** These amounts are *your* financial responsibility. *Copayments* should be paid by or on behalf of the *member* at the time the *covered service* is rendered. Applicable *deductible* and/or *coinsurance* may also be collected.

Your **Summary of benefits** may contain one *copayment* which covers all prenatal and postnatal *visits* for each pregnancy. In most cases, this will be a more favorable benefit than paying the specialist *copayment* for each prenatal and postnatal *visit*. If, for any reason, *your* per- pregnancy *copayment* exceeds the total *copayments you* would have paid if *you* had paid *your* specialist *copayment* for each prenatal and postnatal *visit,* the *HMO* or the *HMO provider* will reimburse *you* the difference between the per- pregnancy *copayment* and the total per *visit* specialist *copayments you* would have paid for all prenatal and postnatal *visits* during any one pregnancy.

Annual limit

Calendar year limit

The **Summary of benefits** lists the calendar year limit for *copayments, coinsurance* or *deductible* (if any). When a *member* reaches the annual calendar year limit, that *member* will no longer be required to pay additional *copayments, coinsurance* or *deductible* (if any) for the remainder of that calendar year. However, when all *members* in the same immediate family satisfy their aggregate calendar year limit, no *member* in that family will be required to pay additional *copayments, coinsurance* or *deductible* (if any) for the remainder of that calendar year. When *members* have reached their calendar year limits, they will be notified by the *HMO* within 30 days.

The *copayments, coinsurance* and *deductible* (if any) for the services listed below are not counted toward the calendar year limit and are never waived. Any *copayments, coinsurance* or *deductible* (if any) paid in excess of the calendar year limit, except those which are never waived, will be promptly refunded to *you*.

What does not count toward this limit

Copayments, coinsurance and *deductible* (if any) for the following services do not apply toward the annual limit:

- routine vision exams;
- *prescription drugs* under *your prescription drug* card benefit.

Any *deductible* amounts carried forward from the prior calendar year do not apply toward the annual limit.

Any charges over the *HMO's maximum allowed amount* are not considered *copayments* or *coinsurance* and do not apply toward the annual limit.

How your HMO pays a claim

The *covered services* available under *your EOC* are to be used only by *you* and *your* covered *dependents. You* may not give permission to anyone else (assign *your* right) to receive *covered services* under *your* coverage.

You may not assign *your* right to receive payment for *covered services.* Prior payments to anyone, whether or not there has been an assignment of payment, shall not constitute a waiver of, or otherwise restrict, the *HMO's* right to direct future payments to *you* or any other individual or facility. Notwithstanding any provision in this *EOC* to the contrary, however, the HMO:

- will reimburse directly any ambulance service provider to whom the *member* has executed an assignment of benefits; and
- will reimburse a non- HMO provider or facility directly for medical screening and stabilization services which were rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act.

Maximum Allowed Amount

General

This section describes how *we* determine the amount of reimbursement for *covered services.* Reimbursement for services rendered by *HMO providers* and non- HMO providers is based on the plan's *maximum allowed amount* for the *covered service* that *you* receive. The *maximum allowed amount* for this plan is the maximum amount of reimbursement the *HMO* will allow for services and supplies:

- that meet *our* definition of *covered services,* to the extent such services and supplies are covered under *your EOC* and are not excluded;
- that are *medically necessary;* and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in *your EOC.*

When *you* receive *covered services* from a provider, *we* will, to the extent applicable, apply processing rules to the claim submitted for those *covered services.* These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect *our* determination of the *maximum allowed amount. Our* application of these rules does not mean that the *covered services you* received were not *medically necessary*. It means *we* have determined that the claim was submitted inconsistent with procedure coding rules and/or

reimbursement policies. For example, *your* provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, *our* payment will be based on a single *maximum allowed amount* for such single procedure code rather than a separate *maximum allowed amount* for each billed code.

Maximum allowed amount for multiple procedures

When multiple procedures are performed on the same day by the same physician or other healthcare professional, *we* may reduce the *maximum allowed amount* for those secondary and subsequent procedures because reimbursement at 100% for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The *maximum allowed amount* may vary depending upon whether the provider is a *HMO provider* or a non- HMO provider. An *HMO provider* is a provider who is in the *HMO* network. For *covered services* performed by an *HMO Provider,* the *maximum allowed amount* for this plan is the rate the provider has agreed with *us* to accept as reimbursement for the *covered services.* Because *HMO providers* have agreed to accept the *maximum allowed amount* as payment in full for that service, they should not send *you* a bill or collect for amounts above the *maximum allowed amount.* However, *you* may receive a bill or be asked to pay a portion of the *maximum allowed amount* if *you* have not met *your deductible, copayment* or *coinsurance* if any. Please call Member Services for help in finding an *HMO provider* or look on www.anthem.com.

Certain *covered services* such as medical supplies, ambulance, early intervention services, *home care services,* private duty nursing, *medical equipment,* and medical formulas, may be rendered by persons or entities that are not providers. There may or may not be networks established for these persons or entities. The *maximum allowed amount* for services from these persons or entities will be determined in the same manner as described above for providers. For *prescription drugs* and diabetic supplies rendered by a pharmacy, the *maximum allowed amount* is the amount determined by *us* using prescription drug cost information provided by *our* pharmacy benefits manager.

Member cost share

For certain *covered services* and depending on *your* plan design, *you* may be required to pay a part of the *maximum allowed amount* as *your* cost share amount (for example, *deductible, copayment,* and/or *coinsurance).*

The *HMO* will not provide any reimbursement for non- covered services. *You* may be responsible for the total amount billed by *your* provider for non- covered services. Both services specifically excluded by the terms of *your* policy/plan and those received after benefits have been exhausted are non- covered services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

Non- participating providers and facilities

If *you* go to a non- participating provider or facility with the proper authorization, *we* may choose to pay *you* or anyone else responsible for paying the bill. *We* will pay only after *we* have received an itemized bill or proof of loss and all the medical information *we* need to process the claim. *We* reserve the right to pay no more for a service *you* receive from a non- participating provider or facility than *we* would have paid a participating provider or facility for the same service.

In the event that payment is made directly to *you, you* have the responsibility to apply this payment to the claim from the non- *HMO* provider. In all cases, *our* payment relieves the *HMO* of any further liability for the service.

When you must file a claim

Most claims will be filed for *you* by *HMO providers. You* may have to file a claim if *you* receive care out- of- area from a provider who is not an *HMO provider.*

In most cases, the *HMO* will reimburse *you* for *covered services* paid for by *you* only if a completed claim (including receipt) has been received by the *HMO* within 180 days of the date *you* received such services.

You will have to file a claim if *you* receive care billed by someone other than a doctor or hospital, or if the provider cannot file a claim for *you.* To file a claim, follow these 3 steps:

1. Call 800- 421- 1880 to order a claim form.
2. Complete and sign the claim form. Attach all itemized bills for *covered services.* Each itemized bill must contain the following:
    - name and address of the person or organization providing services or supplies;
    - name of the patient receiving services or supplies;
    - date services or supplies were provided;
    - the charge for each type of service or supply;
    - a description of the services or supplies received; and
    - a description of the patient's condition (diagnosis).

3. Send the completed claim form and itemized bill(s) to:

HealthKeepers, Inc.
Attention: Operations
P.O. Box 26623
Richmond, VA 23261- 6623

When your claim is processed

In processing *your* claim, the *HMO* may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the **"When you must file a claim"** paragraph of this section will be processed within 30 days of receipt of the claim. The *HMO* may extend this period for another 15 days if the *HMO* determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 30- day period. If the coverage decision involves a determination of the appropriateness or *medical necessity* of services, the *HMO* will make its decision within 2 working days of its receipt of the medical information needed to process the claim.

The *HMO* may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by *you* or *your* provider furnishing the additional information. *You* or *your* provider must submit the additional information to the *HMO* within either 12 months of the date of service or 45 days from the date *you* were notified that the information is needed, whichever is later. Once *your* claim has been processed by the *HMO, you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination,* the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;

- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the *HMO's* appeal procedures and applicable time limits; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist *you* with the internal or external appeals process.

If all or part of a claim was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the *HMO* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

Recovery of overpayments

The *HMO* shall have the right to recover any overpayment of benefits from persons or organizations that the *HMO* has determined to have realized benefits from the overpayment:

- any persons to or for whom such payments were made;
- any insurance company;
- a facility or provider; or
- any other organization.

You will be required to cooperate with us to secure the *HMO's* right to recover the excess payments made on *your* behalf, or on behalf of covered persons enrolled under *your* family coverage.

Under certain circumstances, if we pay the health care provider amounts that are *your* responsibility, such as *deductibles, copayments* or *coinsurance,* we may collect such amounts directly from *you. You* agree that we have the right to collect such amounts from *you.*

When you are covered by more than one health plan

Coordination of benefits ("COB")

Special COB rules apply when *you* or *members* of *your* family have additional health care coverage through other group health plans, including:

- group insurance plans, including other Blue Cross and Blue Shield plans or *HMO* plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax- supported or government program to the extent permitted by law.

Primary coverage and secondary coverage

When a *member* is also enrolled in another group health plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. The decision of which coverage will be primary or secondary is made using benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to the *HMO's,* the other coverage will be primary.
- If a *member* is enrolled as the named insured under one coverage and as a dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a *member* is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the *member* is enrolled as a child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the calendar year will be the primary.
- Special rules apply when a *member* is enrolled as a child under two coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or stepparent with custody will be primary. However, if there is a court order that requires one parent to provide for medical expenses for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the calendar year will be primary.

When the *HMO* provides secondary coverage, *we* first calculate the amount that would have been payable had the *HMO* been primary. Then *we* coordinate benefits so that the combination of the primary plan's payment and the *HMO's* payment does not exceed the amount the *HMO* would have paid had it been primary. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.

The preceding paragraph does not apply to claims for *outpatient prescription drugs* provided by a pharmacy when Medicare Part D provides the covered person's primary *prescription drug* coverage. See the following section for more information.

How prescription drug benefits are coordinated when Medicare Part D is primary

If Medicare Part D provides *your* primary coverage for *outpatient prescription drugs* provided by a pharmacy, *we* first calculate the amount that would have been payable had the *HMO* been primary. *We* then pay a secondary benefit up to that amount, in order to reduce any amount *you* had to pay out- of- pocket under Medicare Part D. The benefit *we* pay is limited to the lesser of the amount *you* paid out- of- pocket under Medicare Part D or the amount the *HMO* would have paid if it had been primary.

Changing your coverage

Who is eligible for coverage

Subscriber

A *subscriber* is eligible for coverage if he/she resides or works in the *service area* and after he/she satisfies the employer's eligibility requirements. Eligibility requirements are available from the *group administrator*. The employer will inform the *subscriber* of the *effective date,* which is agreed upon by the *HMO* and the employer, in accordance with these eligibility requirements.

The subscriber's eligible dependents

Eligible *dependents* include:

- the *subscriber's* spouse or the *subscriber's* domestic partner in accordance with *your* employer's eligibility requirements;
- the *subscriber's* children age 26 or younger which includes:
    - the *subscriber's* newborn, natural child, or child placed with *subscriber* for adoption;
    - the *subscriber's* stepchild; and
    - any other child for whom the *subscriber* has legal guardianship or court- ordered custody.

Your employer may impose special requirements and will inform *you* of any action *you* need to take in order to enroll *your* domestic partner.

The age limit for enrolling children is age 26. Coverage for children will end on the last day of the calendar year in which the children reach age 26.

The age limit does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the *subscriber* provides proof of handicap and dependence at the time of enrollment.

For the child enrolled prior to reaching the age limit, coverage may continue beyond the age limit if the *subscriber* provides proof of handicap and dependence within 31 days after he/she reaches the age limit.

You may be asked to provide an *HMO physician's* certification of the *dependent's* condition.

Types of coverage

The *subscriber's* employer may choose from five enrollment options offered by the *HMO*. The *subscriber* may select the enrollment option, chosen by his/her employer, that meets his/her needs. The options are as follows:

- Employee only
- Employee and spouse or domestic partner
- Employee and one child
- Employee and family
- Employee and children

When you may enroll

You may enroll:

- **During the initial enrollment period**
  The *subscriber* may enroll any eligible *dependents* by completing an *HMO* application to be sent to the *HMO* by the employer. No person is eligible to re- enroll in the *HMO* who has coverage terminated as described in **Termination for cause** on page 50.
- **During open enrollment periods approved by the HMO**
  The coverage of people who enroll during the employer's open enrollment period is effective as agreed upon by the employer and the *HMO* in the Group Enrollment *Agreement*.
- **During a special enrollment period**
  The *subscriber* may have chosen to decline coverage for himself/herself and/or his/her dependents under this health plan when the *subscriber* could have enrolled for it because of coverage under another health plan.

  If the *subscriber* declined coverage under this health plan in writing for himself/herself and/or his/her dependents and later the *subscriber* or his/her dependent(s) loses the other coverage, the *subscriber* may enroll in any benefit package under the plan during a special enrollment period. For example, a special enrollment period of 31 days will be allowed if:

  - the other health plan coverage was under a COBRA continuation and the continuation period ran out;
  - the employer who had been making contributions toward the other health plan coverage stopped making them; or
  - there was a loss of eligibility under the other health plan coverage. Eligibility may have been lost due to:
    - divorce;
    - the death of the *subscriber's* spouse;
    - a reduction in the number of hours of employment;
    - termination of employment for the *subscriber* or *subscriber's* spouse at another company; or
    - for a dependent, cessation of dependent status.

  A special enrollment period of 60 days will be allowed under two additional circumstances:

  - if *your* or *your* eligible dependent's coverage under Medicaid or the Children's Health Insurance Program (SCHIP) is terminated as a result of loss of eligibility; or
  - if *you* or *your* eligible dependent become eligible for premium assistance under a state Medicaid or SCHIP plan.

  Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/SCHIP or of the eligibility determination.

If your family changes

Special enrollment periods are also allowed if *your* family changes. The change may be due to marriage, the birth of a child, or the placement of a child with *you* for adoption. Within 31 days after the change occurs, the *subscriber* will need to complete an application to add dependents or a change form to delete dependents. In all cases, contact the *group administrator* immediately.

Marriage
The *effective date* for *dependents* added as a result of marriage will be determined by the *subscriber's* employer in accordance with its eligibility requirements.

Newborn dependents
A newborn dependent may be covered from the moment of birth. The *subscriber* must submit a completed application and the appropriate premium amount, if any, to the *HMO* within 60 days of the newborn's birth. If an application along with any appropriate premium amount is not received by the *HMO* within 60 days of birth, the child will not be eligible to be added to the *subscriber's* coverage until the next open enrollment period.

Adopted dependents
When a child has been placed with a *subscriber* for adoption, that child is eligible for dependent coverage from the date of the adoption or placement. However, application for coverage must be submitted within 60 days from the date of eligibility, along with proof that the adoption is pending and any appropriate premium amount. If a newborn infant is placed for adoption with the *subscriber* within 60 days of birth, the child shall be considered a newborn child of the *subscriber,* and coverage may be effective from the date of the child's birth. If an application, along with any premium amount, is not received by the *HMO* within 60 days of the adoption or placement for adoption, the child will not be eligible to be added to the *subscriber's* coverage until the next open enrollment period.

When a dependent is no longer eligible for coverage, the *subscriber* can change the type of coverage by completing a change form. The *effective date* of *your* coverage change will be determined by *your* employer in accordance with its eligibility requirements.

The *HMO* may periodically require proof of dependency.

Helpful tip: Any dependent, including a newborn child who is not enrolled in the *HMO* within 60 days after becoming eligible, may not enroll until the employer's next open enrollment period.

Other changes that require notification

Please make sure that the *HMO* and the *subscriber's* employer are notified as soon as possible, but no more than 31 days after any of the following changes occur:

- change in name, address or phone number;
- change in *subscriber's* employment;
- *member* permanently moves outside the *service area;*
- death of a *member;* or
- coverage under another health plan is obtained.

Failure to provide proper notice of these changes in coverage may affect *your* coverage. The *HMO* is not responsible for lapses in coverage due to the *subscriber's* failure or *your* employer's failure to provide proper notice of a change in coverage.

In the absence of fraud, all statements made by a *subscriber* shall be considered representations and not warranties.

No statement shall be the basis for voiding coverage or denying a claim after the *EOC* has been in force for two years from its *effective date,* unless the statement was material to the risk and contained in a written application.

After coverage ends

All rights to benefits, including *inpatient* services, shall cease as of the *effective date* of termination.

Termination for cause

If the *subscriber's* coverage is terminated for cause, the coverage for all dependents is terminated as well. Eligibility for other insurance coverage must be determined by the employer if the *HMO's* coverage is terminated for cause. The conditions under which *your HMO* coverage may be terminated for cause are as follows:

a. If *you* allow someone to use *your* identification card or *you* use another *member's* card, the *HMO* may recall the card and terminate *your* coverage upon 31 days written notice.
b. *You* represent that all information contained in applications, questionnaires, forms, or statements submitted to the *HMO* is true, correct, and complete, and if *you* furnished incorrect or incomplete information which constitutes a material misrepresentation, then *your* coverage may be terminated upon written notice. *Members* terminated for this reason will be responsible to pay charges for all services provided to the *member* that are related to this incorrect or incomplete information.
c. If *you* are guilty of fraud, gross or repeated misbehavior, including but not limited to, abusive behavior to *HMO providers* and the *HMO* administrative personnel in applying for or seeking any benefits under this *EOC,* then the *HMO* may terminate *your* coverage upon 31 days written notice.
d. When, after reasonable efforts (including changing physicians), *you* cannot establish or maintain a satisfactory physician- patient relationship with *your PCP,* the *HMO* may terminate *your* coverage upon 31 days written notice. Evidence of an unsatisfactory physician- patient relationship may include *your* refusal to accept procedures or treatment recommended by *your PCP.* When an *HMO physician* regards such refusal as incompatible with the continuance of the physician- patient relationship and as obstructing the provision of proper medical care, the *HMO* may terminate *your* coverage and disclaim all financial responsibility for any further *covered service* costs incurred by *you.*

Termination for loss of eligibility

Subject to the conversion privileges listed below, the *member's* coverage will cease on the date determined by the *subscriber's* employer in accordance with its eligibility requirements. In the event of the *subscriber's* death, coverage will terminate for covered dependents of the *subscriber* on the last day of the period for which payments have been made by or on behalf of the *subscriber,* subject to the conversion privileges described below.

Termination for employer default

Only *members* for whom the stipulated payment is actually received by the *HMO* shall be entitled to *covered services* and then only for the period for which such payment is received. If payment is not made in full by the employer on or prior to the premium due date, as specified in the *agreement,* a grace period shall be granted to the employer for payment. *We* will allow employers a 31 day grace period to pay monthly premiums, except for the first month's premium. During the grace period, coverage shall remain in effect,

unless the employer has given the *HMO* written notice of discontinuance in accordance with the terms of the *agreement* and in advance of the date of discontinuance. If payment is not made within the grace period, the *HMO* may cancel coverage as of the end of the grace period or 15 days from the date written notice of termination is provided by the *HMO* to the employer, whichever is later.

Termination of the agreement

If the *agreement* between the *HMO* and the employer is terminated, coverage shall terminate for all *subscribers* and dependent *members* as of the *effective date* of termination of the *agreement*. All rights to benefits shall cease as of the *effective date* of termination. There is one exception. *Members* who become totally disabled while enrolled under this *EOC* and who continue to be totally disabled as of the date of termination of the *agreement* may continue their coverage for 180 days, until the *member* is no longer totally disabled, or until such time as a succeeding carrier elects to provide replacement coverage without limitation as to the disabling condition, whichever period is the shortest. Such *members* will be responsible for paying the applicable premiums to the *HMO* for such continuation of coverage.

Reinstatement

Once *your* coverage is terminated, re- application is necessary before new coverage can begin. Note that if *your* coverage is terminated for cause as specified above, *you* are not eligible for reinstatement.

Continuing coverage when eligibility ends

A *subscriber* and enrolled dependents may be eligible for the following:

- continuous group coverage under the COBRA law (Consolidated Omnibus Budget Reconciliation Act);
- non- group conversion coverage; or
- twelve- month continuation.

You may not convert to non- group coverage if *you* are eligible for coverage under either Medicare, a state or federal program providing substantially the same level of benefits, or another group benefit plan providing substantially the same level of benefits. In addition, *you* may not convert to non- group coverage if *you* have not been continuously covered under the *HMO* for three consecutive months prior to the termination of *your* group coverage.

Continuation of coverage (COBRA)

This section pertains to *you* only if *your* employer's group health plan is subject to the requirements of the COBRA law. It generally explains when COBRA continuation coverage may be available to *you* and *your* enrolled family members and what *you* need to do to protect *your* family's COBRA rights.

COBRA continuation is a temporary extension of coverage. *You* and *your* enrolled family members may be *qualified beneficiaries*. A *qualified beneficiary* is eligible for COBRA continuation if coverage would ordinarily end due to a *qualifying event* described in this section. *Qualified beneficiaries* who elect COBRA coverage must pay the full cost for it, without contribution from the employer.

A covered person will become a *qualified beneficiary* if he or she loses coverage because one of the following *qualifying events* occurs:

- *Your* hours of employment are reduced;
- *Your* employment ends for any reason other than *your* gross misconduct;
- *You* die;

- *You* become entitled to Medicare benefits;
- *You* become divorced or legally separated;
- For a covered child, he or she stops being an eligible dependent (for example, by attaining the maximum age for coverage); or
- For covered retirees and their covered family members only, the employer files a proceeding in bankruptcy.

COBRA continuation will be offered only after the *plan administrator* has been notified that a *qualifying event* has occurred. The employer will notify the *plan administrator* unless the *qualifying event* is *your* divorce or legal separation or the loss of a covered child's eligibility. For these *qualifying events, you* must notify the *plan administrator* within 60 days after the *qualifying event.* The form and content of all COBRA- related notices must satisfy *your* employer's requirements. Contact *your group administrator* for instructions.

After receiving timely notice, the *plan administrator* will inform the *qualified beneficiaries* of their right to elect continuation of coverage and of:

- the monthly cost for the coverage;
- the due date of each monthly payment; and
- where the monthly payments should be sent.

Qualified beneficiaries have 60 days in which to elect COBRA continuation using forms that have been approved by the HMO and supplied by the *plan administrator*. Each *qualified beneficiary* has an independent right to elect COBRA coverage. *You* may elect COBRA on behalf of *your* covered spouse, and parents may elect it on behalf of their covered children.

Within 45 days after electing COBRA, the first payment for the coverage must be paid in full, along with any unpaid amounts necessary to pay for coverage through the current month. Thereafter, monthly payments must be made according to the instructions provided by the *plan administrator.*

When the *qualifying event* is:

- *your* death, divorce, legal separation or Medicare entitlement or an enrolled child's loss of eligibility, continuation coverage may last up to 36 months.
- a reduction in *your* work hours or *your* termination of employment, continuation coverage may last up to 18 months. However, if *you* became entitled to Medicare less than 18 months before one of these *qualifying events,* continuation coverage may last up to 36 months after the date of Medicare entitlement for *qualified beneficiaries* other than *you.*

If a *qualified beneficiary* would ordinarily be eligible for 18 months of continuation coverage, that period may be extended for up to 11 additional months if he or she is determined by the Social Security Administration to have been disabled at some time during the first 60 days of COBRA coverage. To be eligible for the 11- month extension, notice must be provided to the *plan administrator:*

- within 60 days after the date of the Social Security Administration's disability determination; and
- before the end of the first 18 months of COBRA coverage.

Other enrolled non- disabled family members of the disabled *qualified beneficiary* are also entitled to the 11- month extension if these requirements are met.

If *your* family experiences another *qualifying event* while receiving 18 months of COBRA continuation coverage, *your* enrolled spouse and child(ren) can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if:

- notice of the second *qualifying event* is properly given to the *plan administrator;* and
- the qualifying event would have caused the spouse or child(ren) to lose coverage under *your* health plan had the first *qualifying event* not occurred.

If *you* have a newborn child, adopt a child, or have a child placed with *you* for adoption during *your* COBRA continuation period, that child will also be a *qualified beneficiary* with COBRA rights. For adding a child or making other changes in dependent coverage, please follow the procedures explained earlier in this booklet.

A *qualified beneficiary's* eligibility for COBRA coverage will end on the earliest of the following dates:

- the date that ends the maximum continuation period described above;
- the date that ends the last period for which a monthly payment was made when due;
- the date the *qualified beneficiary* obtains coverage under any other group health plan that does not contain an exclusion or limitation that is applicable to his or her pre- existing conditions;
- the date the *qualified beneficiary* becomes enrolled in Medicare; or
- the date the employer's group health plan ends.

Once eligibility for COBRA coverage ends, the former *qualified beneficiary* may enroll under any individual program offered by us for which he or she is eligible as explained below.

In order to protect *your* family's COBRA rights, *you* must keep the *plan administrator* informed of any changes in the addresses of family members. *You* should also keep a copy, for *your* records, of any notices *you* send to the *plan administrator*.

If you have any questions, please contact the *plan administrator*. For additional information, *you* may also contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in *your* area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of EBSA offices are available on EBSA's website.

Conversion from group to non- group coverage

To prevent a lapse in coverage, contact the *HMO* within 31 days after issuance of the written notice described in the **Notice of continuation options** section below, but in no event beyond the 60 day period following the date coverage ends. If *your* coverage ends for reasons other than termination for cause, as specified on page 50 of this *EOC,* and *you* meet all eligibility requirements, *you* may convert *your* group coverage to non- group coverage. Contact the *HMO* to obtain an application. A completed application must be submitted along with the appropriate premium payment to the *HMO* within 31 days of the day *your* group coverage ends. Non- group coverage benefits will not necessarily be the same as *your* group coverage benefits. To make sure *you* know what will be covered, read the non- group coverage offer carefully. It will outline:

- enrollment and eligibility requirements;
- the time permitted to accept the offer; and
- the benefits and rates of the individual plan.

Twelve- month continuation

This section pertains to *you* only if *your* employer's group health plan is not subject to the requirements of the COBRA law. Also, even if the employer's group health plan is not subject to the requirements of COBRA, the group policyholder must elect to administer the continuation option set forth in this section for all enrolled employees and their dependents as of its most recent policy renewal or effective date for this section to be effective.

If *you* or a dependent loses eligibility for *your* group's coverage, *you* may be able to continue group coverage for a period of 12 months beginning immediately following the date of the termination of the person's eligibility, without evidence of insurability. The following rules apply:

- the person must have been enrolled under the plan for at least 3 months;
- the person must not be eligible for Medicare or Medicaid benefits prior to the loss of eligibility for group coverage;
- the person must apply for coverage with the group policyholder and pay the first month's premium within 31 days after issuance of the written notice described in the **Notice of continuation options** section below, but in no event beyond the 60 day period following the date of the termination of the person's eligibility;
- premium for such extended coverage is timely paid to the group policyholder on a monthly basis during the twelve- month period; and
- the premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate.

Notice of continuation options

The group *policyholder* shall provide each employee or other person losing coverage under such policy written notice of the opportunity to purchase individual coverage, or if elected by the group *policyholder* with respect to a health plan not subject to COBRA, written notice of the availability of the twelve month continuation option. Such notice shall be provided within 14 days of the *policyholder's* knowledge of your loss of eligibility under the policy. If the group policyholder does not provide the required notice, please contact Anthem Member Services directly within 60 days from the date you lose eligibility for coverage to discuss your continuation options.

Important information about your health maintenance organization coverage

In the event *you* need to contact someone about this coverage for any reason please contact *your* agent. If no agent was involved in the sale of this health maintenance organization coverage, or if *you* have any additional questions *you* may contact HealthKeepers, Inc. at the following address and telephone number:

Address:
HealthKeepers, Inc.
Attention: Member Services
P.O. Box 26623
Richmond, VA 23261- 6623

Telephone:
804- 358- 7390
in Richmond
800- 421- 1880
from outside Richmond

Written correspondence is preferable so that a record of *your* inquiry is maintained. When contacting *your* agent, HealthKeepers, Inc., or the Bureau of Insurance, have *your* contract number ready.

We recommend that *you* familiarize yourself with *our* grievance procedure, and make use of it before taking any other actions.

Statement of ERISA rights

As a participant in *your* plan *you* may be entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

If *you* are entitled to ERISA rights *you* may examine, without charge, at the *plan administrator's* office and at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by *your* plan with the Department of Labor (such as detailed annual reports), and plan descriptions.

You may obtain copies of all plan documents and other plan information by writing to the *plan administrator*. The *plan administrator* may make a reasonable charge for the copies.

Helpful tip: ERISA generally does not apply to church plans or to government plans (such as plans sponsored by city, county, or state governments, or by public school systems).

Plan "fiduciaries"

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate *your* plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of *you* and other plan participants.

- No one may terminate *your* employment or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising *your* rights under ERISA.

- If *your* claim for a welfare benefit is denied in whole or in part, *you* may receive a written explanation of the reason for the denial.
- *You* have the right to have the *plan administrator* review and reconsider *your* claim.

Enforcement of ERISA rights

Under ERISA, there are steps to enforce the above rights. For instance:

- If *you* request materials from the plan and do not receive them within 30 days, *you* may file suit in a federal court. In such a case, the court may require the p*lan administrator* to provide the materials and pay *you* up to $110 a day until *you* receive the materials (unless the materials were not sent because of reasons beyond the control of the Administrator).
- If *you* have a claim for benefits or an appeal of a coverage decision, which is denied or ignored, in whole or in part, *you* may file suit in a state or federal court.
- If plan fiduciaries misuse the plan's money or if *you* are discriminated against for asserting *your* rights, *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in a federal court. The court decides who pays court costs and legal fees.

If *you* are successful, the court may order the person *you* have sued to pay these costs and fees. If *you* lose, the court may order *you* to pay these costs and fees, if, for example, it finds *your* claim to be frivolous.

Assistance

If *you* have questions about *your* plan, contact *your plan administrator*. If *you* have questions about this statement about *your* rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in *your* telephone directory. *You* may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Employer premiums

The *subscriber's* employer is responsible for paying a monthly premium by the first day of the month for which coverage is purchased. *We* will allow employers a 31 day grace period to pay monthly premiums, except for the first month's premium. During this grace period, coverage will continue unless *we* receive a written notice of termination from the employer. *We* will notify the employer at least 15 days prior to terminating coverage for non- payment of a monthly premium. The *HMO* is not responsible for costs *you* incur during any period (other than the grace period discussed above) when *your* employer fails to pay full premiums.

Changes in your HMO

The *HMO* may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of coverage under this *EOC*. Any provision, term, benefit, or condition of coverage and this *EOC* may be amended, revised, or deleted in accordance with the terms of the *agreement* between the *HMO* and the employer. This may be done without the *member's* consent or concurrence.

Notice in writing

From the HMO to you. A notice sent to *you* by the *HMO* is considered "given" when received by the *subscriber's* employer at the address listed in the *HMO's* records or, if sent directly to *you,* the notice is considered "given" when mailed to the *subscriber's* last known address as shown in the *HMO's* enrollment records. Notices include any information which the *HMO* may send *you,* including identification cards.

From you or your employer to the HMO. Notice by *you* or the *subscriber's* employer is considered "given" when actually received by the *HMO.* The *HMO* will not be able to act on this notice unless the *subscriber's* name and identification number are included in the notice.

Group enrollment agreement

The *HMO* and the *subscriber's* employer have entered into an *agreement* for the provision of the benefits outlined in this *EOC.* Under this *agreement,* the *subscriber's* employer will contribute on *your* behalf a portion of the premiums required. In the event of any inconsistency between the information contained in this *EOC* and the *agreement* between the *HMO* and the *subscriber's* employer, the *agreement* will control. *You* may direct specific questions related to the *agreement* between the *HMO* and the *subscriber's* employer to the employer.

The *agreement* and this *EOC* (including any amendments thereto) constitute the entire contractual *agreement* between the *HMO* and the *subscriber's* employer and no portion of the charter, by- laws, or other document of the *HMO* shall constitute part of the contract unless it is set forth in full in the *agreement* or *EOC.*

Complaint and appeal process

In order for the *HMO* to remain responsive to *your* needs, the *HMO* has established both a complaint process and an appeal process. Should you have a problem or question about the *HMO,* a Member Services representative will assist you. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal with the *HMO.* Complaints typically involve issues such as dissatisfaction about *HMO* services, quality of care, the choice of and accessibility to *HMO providers* and network adequacy. Appeals typically involve a request to reverse a previous decision made by the *HMO.* Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, *your* complaint will be reviewed and investigated. *You* will receive a response within 30 calendar days of the *HMO's* receipt of *your* complaint. If the *HMO* is unable to resolve *your* complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve *your* complaint. The *HMO* will then respond to *you* within an additional 30 calendar days. Written complaints may be filed to the following address:

HealthKeepers, Inc.
Attention: Member Services
P.O. Box 26623
Richmond, VA 23261- 6623

Appeal Process

The *HMO* is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions *you* find unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Types of appeals include:

- internal appeals are requests to reconsider rescissions or coverage decisions of *pre-service* or *post-service claims.* Expedited appeals are made available when the application of the time period for making *pre-service* or *post-service* appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain; and
- external reviews are requests for an independent, external review of coverage decisions made by the *HMO* through its internal appeal process. More information about this type of appeal may be found in the "**Independent external review of adverse utilization review decisions**" paragraph of this section.

How to appeal a coverage decision

To appeal a coverage decision (including a rescission), please send a written explanation of why *you* feel the coverage decision was incorrect. *You* or *your* authorized representative acting on *your* behalf may submit the written explanation. Alternatively, this information may be provided to a Member Services representative over the phone. This is *your* opportunity to provide any comments, documents or information that *you* feel the *HMO* should consider when reviewing *your* appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- *your* identification and group number (as shown on *your* identification card); and
- in the case of a claim, the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

You may contact Member Services with *your* appeal at the following:

Address:
HealthKeepers, Inc.
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Telephone:
804-358-7390
in Richmond
800-421-1880
from outside Richmond

You must file *your* appeal within either 15 months of the date of service or 180 days of the date *you* were notified of the *adverse benefit determination,* whichever is later.

How the HMO will handle your appeal

In reviewing *your* appeal, the *HMO* will take into account all the information *you* submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing *your* appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non- restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will promptly acknowledge receipt of *your* appeal, and will resolve and respond to it as follows:

- For *pre- service claims, we* will respond in writing within 30 days after receipt of the request to appeal;
- For *post- service claims* and recissions*, we* will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, *we* will respond to *you* and *your* provider as soon as possible taking into account *your* medical condition, but not later than 72 hours from receipt of the request.

We will also provide *you,* free of charge, with any new or additional evidence considered, relied upon, or generated in connection with *your* claim. In addition, before *you* receive an *adverse benefit determination* based on new or additional rationale, *we* will provide *you,* free of charge, with the rationale.

When our review of *your* appeal has been completed, *you* will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. *You* will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

If *we* deny *your* appeal, *you* will be provided with other dispute resolution options as applicable, including external review through the Bureau of Insurance.

Independent external review of adverse utilization review decisions

If *we* have denied *your* claim, *you* may have the right to request an independent external review of our decision by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment *you* requested (including whether the service or treatment was determined to be experimental or investigative). Except when an expedited external review is warranted as described below, the external review process is available only if the denial is upheld after *you* file an internal appeal with us. This is called a standard external review.

You or *your* authorized representative may request an expedited external review with the Bureau of Insurance at the same time as exercising our expedited appeal process. An expedited external review may also be requested if our adverse decision was based upon our judgment that the services rendered were experimental or investigative and *your* treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

If *you* have not already requested an expedited external review in advance of our decision to deny *your* claim on appeal, *you* may do so after our appeal decision if:

- *you* have a medical condition where the time frame for completion of a standard external review would seriously jeopardize *your* life, health or ability to regain maximum function;
- this decision concerns an admission, availability of care, continued stay, or health care service for which *you* received emergency services, but have not been discharged from a facility; or
- this decision is based on our judgment that the services rendered were experimental or investigative and *your* treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

To request a standard or expedited external review with the Bureau of Insurance you may contact the Corporate Appeals department listed above, or contact the Bureau of Insurance directly at: Bureau of Insurance – External Review P.O. Box 1157 Richmond VA 23218, Telephone: 877- 310- 6560, E- Mail:externalreview@scc.virginia.gov

Virginia Bureau of Insurance

If *you* have been unable to contact or obtain satisfaction from the *HMO, you* may contact the Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, in Richmond 804- 371- 9741, from outside Richmond 800- 552- 7945, national toll- free number 877- 310- 6560.

The Office of the Managed Care Ombudsman

If *you* have any questions regarding an appeal or grievance concerning the health care services that *you* have been provided which have not been satisfactorily addressed by the *HMO, you* may contact the Office of the Managed Care Ombudsman for assistance at any of the following:

Address:
The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Telephone:
804- 371- 9032
in Richmond

877- 310- 6560
from outside Richmond

E- Mail:

ombudsman@scc.virginia.gov

Web Page:
Information regarding the Ombudsman may be found by accessing the State Corporation Commission's web page at: http://www.scc.virginia.gov

The Virginia Department of Health Office of Licensure and Certification

If *you* have any questions regarding an appeal or grievance concerning the health care services that *you* have been provided which have not been satisfactorily addressed by the *HMO, you* may contact the Virginia Department of Health Office of Licensure and Certification for assistance at any of the following:

Address:
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233

Telephone:
Complaint Hotline: 800- 955- 1819
Richmond Metropolitan Area: 804- 367- 2106
Fax:
804- 527- 4502
E- Mail:
mchip@vdh.virginia.gov

Limitations of damages

In the event a *member* or his representative sues the *HMO,* or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this *EOC,* the damages shall be limited to the amount of the *member's* claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This *EOC* does not provide coverage for punitive damages, or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and shall not be construed, to affect in any manner any recovery by a *member* or his representative of any non- contractual damages to which a *member* or his representative may otherwise be entitled.

Time limits on legal action

No action at law or suit in equity shall be brought against the *HMO* more than one year after the date the cause of action first accrued with respect to any matter relating to:

- this *EOC;*
- the *HMO's* performance under this *EOC;* or
- any statements made by an employee, officer, or director of the *HMO* concerning the *EOC* or the benefits available.

The cause of action shall be deemed to have accrued 180 days after the *HMO's* initial decision if *you* do not initiate an appeal pursuant to the *HMO's* appeal process or an independent external review of an adverse utilization review decision through the Bureau of Insurance. Otherwise, the cause of action will be deemed to have accrued after the final decision of the *HMO* or Bureau of Insurance external review process.

The HMO's continuing rights

On occasion, *we* may not insist on *your* strict performance of all terms of this *EOC.* This does not mean *we* waive or give up any future rights *we* have under this *EOC.*

Laws governing the HMO

The *HMO* is subject to the laws of the Commonwealth of Virginia.

This coverage is a Managed Care Health Insurance Program subject to regulation in the Commonwealth of Virginia by both the Virginia State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

The HMO's relationship to providers

The choice of an *HMO provider* is solely the *member's. HMO providers* are neither employees or agents of the *HMO. We* can contract with any appropriate provider or facility to provide services to *you. Our* inclusion or exclusion of a provider or a covered facility is not an indication of the provider's or facility's quality or skill. *We* make no guarantees about the health of any *HMO providers. We* do not furnish *covered services,* but only make payment for them when received *by members.*

We are not liable for any act or omission of any *HMO provider,* nor are *we* responsible for an *HMO provider's* failure or refusal to render *covered services* to a *member.*

Special limitations

The rights of *members* and obligations of the *HMO* are subject to the following special limitations: To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other *emergency* or similar event not within the control of the *HMO* results in the facilities, personnel, or financial resources of the *HMO* being unavailable to provide or arrange for the provision of *covered services,* the *HMO* shall make a good faith effort to provide or arrange for the provision of such health services taking into account the impact of the event. In such an event, the *HMO* and *HMO providers* shall render covered hospital and medical services insofar as practical, and according to their best judgment. The *HMO* and *HMO providers* shall incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.

Member rights and responsibilities

Successful relationships take a strong commitment from all sides – with each side recognizing the rights and responsibilities of the other. *Your* health care is no different. It takes strong team work between *you, your* health care professionals, and *Anthem* for coverage *you* can count on. Below is a statement of rights and responsibilities that guide our relationship with *you.* Please read through them, and should *you* have any questions, don't hesitate to give us a call.

We are committed to:

- Recognizing and respecting *you* as a member.
- Encouraging *your* open discussions with *your* health care professionals and providers.
- Providing information to help *you* become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of *you* as a member.

You have the right to:

- Participate with *your* health care professionals and providers in making decisions about *your* health care.
- Receive the benefits for which *you* have coverage.
- Be treated with respect and dignity.
- Privacy of *your* personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and *your* rights and responsibilities.
- Candidly discuss with *your* physicians and providers appropriate or *medically necessary* care for *your* condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's *members*' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions *we* (or our designated administrators) make, *your* coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by *your* physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- For assistance at any time, contact *your* local insurance department: by phone in Richmond (804) 371- 9741, from outside Richmond (800) 552- 7945, or in writing: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218.

You have the responsibility to:

- Choose a participating *primary care physician* if required by *your* health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.

- Keep scheduled appointments with *your* doctor, and call the doctor's office if *you* have a delay or cancellation.
- Read and understand to the best of *your* ability all materials concerning *your* health benefits or ask for help if *you* need it.
- Understand *your* health problems and participate, along with *your* health care professionals and providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that *we* and/or *your* health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that *you* have agreed on with *your* health care professional and provider.
- Tell *your* health care professional and provider if *you* do not understand *your* treatment plan or what is expected of *you*.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Member Services Department know if *you* have any changes to *your* name, address, or family members covered under *your* policy.
- Provide *us* with accurate and complete information needed to administer *your* health benefit plan, including other health benefit coverage and other insurance benefits *you* may have in addition to *your* coverage with *us*.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Group Enrollment Agreement and this Evidence of Coverage, and not by this Member Rights and Responsibilities statement.

Definitions

Agreement
is the group enrollment agreement between the HMO and the subscriber's employer, of which this EOC is one part.

Activities of daily living
are walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

Adverse benefit determination
is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the HMO.

Applied behavior analysis
means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Coinsurance
is the percentage of the maximum allowed amount that you pay for some covered services.

Copayment
is the fixed dollar amount you pay for most covered services, such as a doctor's visit.

Covered services
are those medically necessary hospital and medical services which are described as covered in this EOC and which are performed, prescribed or directed by a physician.

Deductible
is a fixed dollar amount of covered services you pay in a calendar year before the HMO will pay for any remaining services during that calendar year.

Effective date
is the date coverage begins for you and/or your dependents enrolled in the HMO.

Emergency
is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity; this includes severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Enrollment date
means your first day of coverage under your employer's group health plan or, if your employer's plan imposes a waiting period for eligibility, the first day of your waiting period.

Experimental/investigative
is any service or supply that is judged to be experimental or investigative at the HMO's sole discretion. Refer to **Exhibit A** for more information.

Evidence of Coverage ("EOC")
is the document that fully explains your health care benefits.

First- tier drugs
have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi- source brand drugs.

Group administrator
is the benefits administrator at the subscriber's employer.

High dose
is a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

HMO physician
is a duly licensed doctor of medicine or osteopathy who has contracted with the HMO to provide medical services to members.

HMO provider
is a medical group, HMO physician, hospital, skilled nursing facility, pharmacy, or any other duly licensed institution or health professional who has contracted with the HMO or its designee to provide covered services to members. A list of HMO providers is made available to each subscriber prior to enrollment. A current list may be obtained from the HMO upon request and may be seen by visiting the HMO's website page at www.anthem.com. The list shall be revised by the HMO from time to time as the HMO deems necessary.

HMO, we, us, our
refers to HealthKeepers, Inc.

Home care services
are services rendered in the home setting. Home care includes services such as skilled nursing visits and physical, speech, and occupational therapy for patients confined to their homes. This also means home infusion services; which is therapy including such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Home infusion therapy does not require that the patient is confined to his/her home.

Inpatient
refers to a person receiving care while you are a bed patient in a hospital or skilled nursing facility.

Maintenance medications
are those you take on a regular, recurring basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes.

Maximum allowed amount
is the allowance as determined by the HMO for a specified covered service or the provider's charge for that service, whichever is less.

Medical director
is a duly licensed physician or his designee who has been designated by the HMO to monitor the provision of covered services to members.

Medical equipment (durable)
is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for activities of daily living purposes.

Medically necessary
to be considered medically necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy- related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider.

Member
is any subscriber or enrolled dependent.

Mental health and substance abuse services
are for the diagnosis and treatment of a psychiatric condition, including nervous, mental, and emotional disorders, and alcohol and drug abuse.

Outpatient
refers to a person receiving care in a hospital outpatient department, emergency room, professional provider's office, or your home.

Outpatient mental health services
are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Partial day services
include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance abuse, or an intensive *outpatient* program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence. Partial day services are used as an alternative to inpatient treatment.

Plan administrator
is your group administrator or the person selected by your employer to administer the continuation of coverage (COBRA) provision.

Post- service claims
are all claims other than pre- service claims and urgent care claims. Post- service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.

Pre- existing condition
is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six- month period ending on the enrollment date.

Pre- service claims
are claims for a service where the terms of the EOC require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post- service claim.

Prescription drugs
are medicines, including insulin and growth hormones, that require a prescription order from your doctor.

Primary care physician ("PCP")
is the HMO physician you must select to provide primary health care and to coordinate the other covered services you may require. PCPs specialize in the areas of general practice, family practice, internal medicine, and pediatrics.

Qualified beneficiary
is the subscriber or a covered dependent who is eligible to continue coverage under COBRA.

Qualifying event
is an event that causes you or your enrolled dependents to select continuation of coverage under COBRA. The events are detailed in the **After coverage ends** section.

Referral
is authorization from your PCP to receive services from another provider, however *your* coverage does not require that *you* obtain a referral from *your PCP* to receive care from other *HMO* providers.

Retail health clinic
is a clinic that provides limited basic medical care services to members on a "walk- in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physician's assistants and nurse practitioners.

Second- tier drugs
will have a higher copayment than first- tier drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi- source brand drugs.

Service area
is the geographic area within which covered services are available.

Special condition
is a condition or disease that is life- threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.

Stay
is the period from the admission to the date of discharge from a facility, including hospitals, hospices and skilled nursing facilities. All facility stays, for the same or related condition, less than 72 hours apart are considered the same stay, and a new inpatient copayment will not apply.

Subscriber
is the eligible employee as defined in the agreement who has elected coverage for himself/herself and his/her dependents (if any) who meet the eligibility requirements of this EOC and enrolls in the HMO, and for whom the premium required by the agreement has been paid to the HMO.

Telemedicine services
means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine services do not include an audio- only telephone conversations, electronic mail message, or facsimile transmission.

Third- tier drugs
will have a higher copayment than second- tier drugs. This tier will contain non- preferred or high cost medications. This tier may include generic, single source brand drugs, or multi- source brands drugs.

Urgent care claims
are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain. Notwithstanding any provision of this EOC, services for a true emergency do not require PCP referrals or any type of HMO advance approval.

Urgent care situations
are medical conditions that require immediate attention, but are not as severe as an emergency. Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury.

Visit
is a period during which a member meets with a provider to receive covered services.

You, your
any member.

Exhibit A

Experimental/Investigative Criteria

Experimental/investigative means any service or supply that is judged to be experimental or investigative at the *HMO's* sole discretion. Nothing in this exclusion shall prevent a *member* from appealing the *HMO's* decision that a service is experimental/investigative. Services which do not meet each of the following criteria will be excluded from coverage as experimental/investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

   a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
      - the following three standard reference compendia defined below:
        1) American Hospital Formulary Service - Drug Information
        2) National Comprehensive Cancer Network's Drugs & Biologics Compendium
        3) Elsevier Gold Standard's Clinical Pharmacology
      - in substantially accepted peer- reviewed medical literature. Peer- reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer- reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

   b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

   Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer- reviewed medical and scientific literature to let *us* judge the safety and efficacy.

3. The available scientific evidence must show a good effect on health outcomes outside a research setting.

4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered experimental/investigative.

Clinical Trial Costs

Clinical trial cost means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

1) The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial;
2) Treatment provided by a clinical trial is approved by:
   - The National Cancer Institute (NCI);
   - An NCI cooperative group or an NCI center;
   - The U.S. Food and Drug Administration in the form of an investigational new drug application;
   - The Federal Department of Veterans Affairs; or
   - An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI;
3) With respect to the treatment provided by a clinical trial:
   - There is no clearly superior, non- investigational treatment alternative;
   - The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non- investigational alternative;
   - The *member* and the physician or health care *provider* who provides the services to the *member* conclude that the *member's* participation in the clinical trial would be appropriate; and
4) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

"Patient cost" under this paragraph means the cost of a *medically necessary* health care service that is incurred as a result of the treatment being provided to the *member* for purposes of a clinical trial. "Patient cost" does not include (i) the cost of non- health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Index

	page
Acupuncture	31
Ambulance	14
Anesthesia	15
Annual Copayment Limit	39
Appeals	58, 63
Appliances or Medical Equipment (Durable)	20, 34
Babies (or Newborn)	19
Birth Control (or Family Planning)	32
Brand Name Drugs (or Prescription Drugs)	22
Canceling Coverage (or After Coverage Ends)	50
Changing Coverage	46
Chemotherapy	27
Children (or Dependents)	46
Chiropractic Care (or Spinal Manipulation or Manual Medical Interventions)	26
Claim Filing	42
Clinical Trials	71
COBRA	51
Coinsurance	65
Continuing Coverage when Eligibility Ends	51
Coordination of Benefits	44
Cosmetic Surgery	31
Deductible	1
Dental (Oral Surgery or Periodontal Surgery)	15, 31
Dependents	46
Diagnostic Tests	15
Dialysis	16
Doctor Visits (or Office Visits)	16
Drugs	21, 35
Eligibility for Coverage	46
Emergency Care	9, 16
Equipment or Medical Equipment (Durable)	19
Exclusions	31
Experimental services	32, 70
Family Counseling	21
Family Planning (or Birth Control)	32
Fetal Screenings	19
Filing a Claim	42
Foot care	32
Generic Drugs (or Prescription Drugs)	22
Grievances (or Appeals)	58, 63
Hearing	33
Home Health services	17, 33
Hospice Care	17
Hospital Admissions	11
Hospital Service	17, 33
Immunizations	29, 33
Infants	19
Infertility	32
Infusion	18
Injectable Medications	20
Inpatient	66
Investigative	32, 70
Lab (or Diagnostic Testing)	15
Legal Action	61
Manual Medical Interventions (or Spinal Manipulation or Chiropractic Care)	26
Marital Counseling	21
Maternity	19
Maximum allowed amount	17

page

Medical Equipment (Durable) 19, 67
Mental Health. 20, 34
Morbid Obesity 35
Newborn 19
Nursing Care (or Home Health or Private Duty Nursing). 17
Nursing Facility (or Skilled Nursing Facility) 26, 37
Nutrition Counseling 35
Obesity. 35
Occupational Therapy 27
Office Visits 16
Oral Surgery (or Dental or Periodontal Surgery) 27
Phone Numbers . . . . . inside front cover
Physical Therapy 27, 37
Pre- existing condition 12
Pregnancy. 19
Premiums. 56
Prescription Drugs 21, 35
Preventive Care 28
Privacy 63
Private Room (or Hospital services) 18
Primary care physician 6, 68
Psychiatric/Psychological Care 20, 35

page

Radiation Therapy 28
Referral. 6, 68
Respiratory Therapy 28
Rights and Responsibilities 63
Routine Wellness 29
Skilled Nursing Facility 26, 37
Speech Therapy 27, 37
Spinal Manipulations 26
Spouses (or Dependents) 46
Substance Abuse (or Mental health) 20, 34
Supplies or Medical Equipment (Durable) 20
Surgery. 26
Termination of Coverage (or Cancellation of Coverage). 50
Therapy 27, 37
Transplants. 27, 35
Urgent Care 9
Vision Care. 30
Weight loss. 35
Well child. 29
Wellness services 28
X- ray (or Diagnostic Testing) 15

End of Evidence of Coverage

Special features and programs

We may offer health or fitness related program options to the group to purchase. If *your* group has selected this option, *you* may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. (Use of gift cards for purposes other than for qualified medical expenses may result in taxable income to you. For additional guidance, please consult *your* tax advisor.) These programs are not covered services under the plan but are in addition to plan benefits; these program features are not guaranteed under *your* certificate and could be discontinued at any time.

In addition to the health and wellness benefits under *your* health plan, or any health or fitness related program options that may be offered to your group to purchase, *our* 360° Health® program surrounds *you* and *your* family members with 360 degrees of preventive care resources, wellness information, savings and incentives and care management services.

Our 360° Health program focuses on helping *you* manage *your* health and make the right health care decisions for *you* and *your* family. Whether you're healthy or have medical conditions, *you* can turn to the programs that make up 360° Health. The program components are each designed to help *you* get the right care at the right time and help *you* lead the healthiest life possible. All the parts of 360° Health are located in one consumer- friendly source on anthem.com that *you* can tap into whether you're healthy and just want to stay that way or living with a chronic condition that needs regular attention.

Although these services are not part of the health and wellness benefits under *your* health plan, they are provided to *you* as a plan participant. Discount services are available through networks administered by other companies - many of which are national leaders in their fields. The discount services listed below are not covered as benefits under *your* health plan and can be discontinued at any time.

Health resources and tools

MyHealth@Anthem®

When *you* visit anthem.com, *you* can access this personalized online resource center. It's full of interactive tools to help *you* assess, manage and improve *your* health. *You* can take advantage of:

- Health risk assessments – Learn *your* overall health status by completing a health risk assessment.
- LEAP Fitness Program – Use the Lifetime Exercise Adherence Program (LEAP) to create online fitness programs and personalized activity plans.
- Condition Centers – When *you* visit a Condition Center, *you* can access in- depth, condition- specific health assessments and personalized treatment options. Condition Centers exist for allergy, anxiety, diabetes, prostate health, breast health and more.
- Physician Pre- Visit Questionnaire – Use this to get ready for *your* next doctor's visit. It can help *you* ask the right questions and communicate effectively with *your* doctor.
- Child Health Manager and Pregnancy Planner – Track *your* children's doctor visits, immunization records and any medical concerns *you* have. Expectant mothers can track their pregnancy check- ups, tests, progress and more.

- Message Center and Health News – Receive health- related secure e- mails with current news, drug alerts and health tips based on *your* personal health interests and profiles.
- Depression and Anxiety Screening – Answer general questions about depression and anxiety. Based on *your* responses, a nurse care manager may follow up with *you* to discuss treatment options and offer support.

AudioHealth Library
For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, there's the AudioHealth Library. It's accessible by phone with more than 400 recorded health topics.

Online Preventive Guidelines
At anthem.com, *you* can use the online preventive guidelines to check on when *you* should have certain check- ups, immunizations, screenings and tests.

Healthy Solutions Newsletter
Mailed to *your* home twice a year, this wellness and benefits newsletter can help *you* make wiser decisions about *your* health and the care *you* need. Packed with practical information, it can help *you* get the most value out of *your* health care benefits.

SpecialOffers@Anthem℠
With SpecialOffers@Anthem, *you* can access discounts on a wide variety of health and wellness products and services. Find deals on natural health and wellness products; acupuncture, chiropractic and massage therapy; fitness club memberships; weight management; laser vision correction and recommended health and wellness books.

The discount programs and services available through SpecialOffers@Anthem are continually reviewed for opportunities to provide more value to *your* membership. For the most up- to- date information, always refer to SpecialOffers@Anthem at anthem.com. These discount programs and services are independent of *your* plan benefits and may change or be cancelled at any time.

Health guidance

Staying Healthy Reminders
Postcards and phone calls remind *you* and *your* family when it's time for certain preventive care or screenings like immunizations, mammograms and colorectal cancer screening tests. *Members* identified with hypertension are sent reminders for certain tests and medication refills.

24/7 NurseLine
Illness or injury can happen, no matter what time of day. As an *HMO member you* have access to a team of nurses, available to assist with *your* questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and *you* can call as often as *you* like. Call 800- 382- 9625.

Future Moms
This program promotes healthy pregnancies and is designed for all expectant women – whether they're experiencing routine pregnancies or at highest risk for complications. When *members* enroll in the Future Moms program, they receive an up- to- date prenatal care package with valuable information for the whole family. A team of nurses – specializing in obstetrics and experienced in working with expectant mothers – is available 24/7 to help *members* try and have the healthiest pregnancies possible.

MyHealth Advantage
We know that early detection of potential health issues can lead to better health. And overall better health may reduce *your* annual doctor *visits* which can lead to annual cost savings for you. MyHealth Advantage conducts ongoing reviews of *your* health status by checking *your* prescribed medications and alerting *you* and *your* doctor about potential drug interactions, overdue exams or recommended tests. And if MyHealth Advantage identifies issues like these for you, you may receive a **MyHealth Note** in the mail. These personalized notices include information about health recommendations and potential pharmacy savings, and feature a summary of *your* recent claims data to keep for *your* records and share with *your* treatment providers.

Health management and coordination

ComplexCare
This program helps members living with multiple health care issues. *Our* goal is to help *you* access quality care, learn to effectively manage *your* condition and lead the healthiest life possible. When *you* enroll in the program, you're assigned to a nurse care manager who specialized in helping high- risk people.

The nurse care manager will work with *you* and *your* doctor to create an individualized care plan, coordinate care between different doctors and health care providers, develop personalized goals, offer health and lifestyle coaching, answer *your* questions and more.

ConditionCare
If *you* or a family member suffers from a chronic condition like asthma, *we* may be able to help *you* achieve better health. *Our* ConditionCare program gives *you* personalized support to take charge of *your* health and maybe even improve it.

We'll help *you* manage *your* symptoms related to pediatric and adult asthma, chronic obstructive pulmonary disease, pediatric and adult diabetes (Types I and II), heart failure, coronary artery disease and kidney disease. The ConditionCare program gives *you:*

- 24- hour toll- free access to registered nurses who can answer *your* questions, provide support and educate *you* on how to best manage *your* condition.
- A health evaluation and consultation with a registered nurse over the phone, when needed, to help *you* manage *your* condition.
- Educational materials like care diaries, self- monitoring charts and self- care tips.

To enroll in the ConditionCare program, call us toll- free at 800- 445- 7922.

Vision Program

To help *you* care for *your* eyes, valuable vision discounts are available to *you* in addition to the routine vision benefits defined in the **What is covered** section of this *EOC*. In order to take advantage of the available discounts, *you* should seek care from a Blue View Vision participating provider.

Your Eyewear Discounts

When *you* visit a Blue View Vision participating eye care professional or vision center, *you* will pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non- disposable) contact lenses as *you* would like.

Your eyewear discounts/costs at participating Blue View Vision provider offices are as follows:

Service	Member Cost*
Frame	35% off retail price
Standard Plastic Lenses	
Single Vision	$50
Bifocal	$70
Trifocal	$105
Lens Options	
UV Coating	$15
Tint (Solid and Gradient)	$15
Standard Scratch- Resistance	$15
Standard Polycarbonate	$40
Standard Progressive (Add- on to bifocal)	$65
Standard Anti- Reflective Coating	$45
Other Add- ons and Services	20% off retail price
Contact Lenses	
Conventional (non- disposable) - materials only	15% off retail

*Discounts apply towards a complete pair of eyeglasses. If eyeglass materials are purchased separately, a 20% discount is applied.

Plus, Anthem *members* have access to discounts on laser vision correction surgery and other vision discounts through SpecialOffers@Anthem.

HealthKeepers, Inc.
P.O. Box 26623
Richmond, VA 23261- 6623

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM and 360º Health are registered trademarks 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.

01/01/2012
Date Created 3/27/12 14:47:06
20120101_MBHKRandolphMaconCollegeHK20201000_INMODIFY