Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Ready to choose *your benefits?*

We can point you in the right direction.

Anthem HealthKeepers
Effective January 1, 2018

This guide is information only. You must enroll to be covered.

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Let's take a look

We know picking a health plan is a big deal, so this guide makes it easier for you to understand your benefit options. We'll explain how the plan works and give you other important details. That way you can enroll with confidence!

In this guide, you'll find:

- The plan at a glance
- How to use your health plan
- Your privacy and rights

Pay a visit to anthem.com to get an idea of what you can do once you're a member. Find a doctor, estimate care costs, sign up to get emails instead of mail and much more!

The plan at a glance

Here's a quick overview of the plan your employer is offering.*

POS Open Access

- The **Point of Service** (POS) plan lets you see doctors and specialists without a referral from your regular doctor, also known as a primary care doctor.
- This plan covers services from a network of doctors and hospitals in your area.
- You pay less for care if you see a doctor in the POS plan.
- You pay a bit more if you see a doctor outside of the POS plan.

It pays to get care in the plan.

Doctors, hospitals and other health care professionals in our plans charge our members lower rates.

* Each of our plans may have different rules, so always check your plan details for more specific information.

Using your health plan

How to get started with your plan and make the best of your benefits

Choose a doctor in your plan

Avoid getting care from doctors outside of your plan; it will cost you more or your plan may not cover it at all. We've made it easy for you to find doctors in your plan. Just use our **Find a Doctor** tool on **anthem.com** to look for a primary care doctor, hospitals, labs and other health care professionals in your plan.

Get your ID card

After you enroll in a plan, you can access your mobile ID card on the Anthem Anywhere mobile app. It's like your passport to care since you'll need to show it whenever you go to the doctor.

Anthem.com

No matter which plan you choose, you can register at **anthem.com** or on the Anthem Anywhere mobile app to get personalized information about your health plan. Use the self-service tools to:

- Find a doctor.
- Estimate your costs, before you step into the doctor's office.

Learn more at **anthem.com/guidedtour**.

Preventive care is covered at no extra cost

Preventive care from a doctor in your plan is covered at 100%. Getting these regular checkups, screenings and shots can help you stay healthy and catch problems early – when they're easier to treat. So, talk to your doctor about what preventive care you may need to protect your health.

Save emergency room visits for emergencies only

Knowing where to go for care saves you time and money. So if you have a real emergency, head straight to the ER or call 911. Otherwise, visit your regular doctor or an urgent care center for minor medical issues.

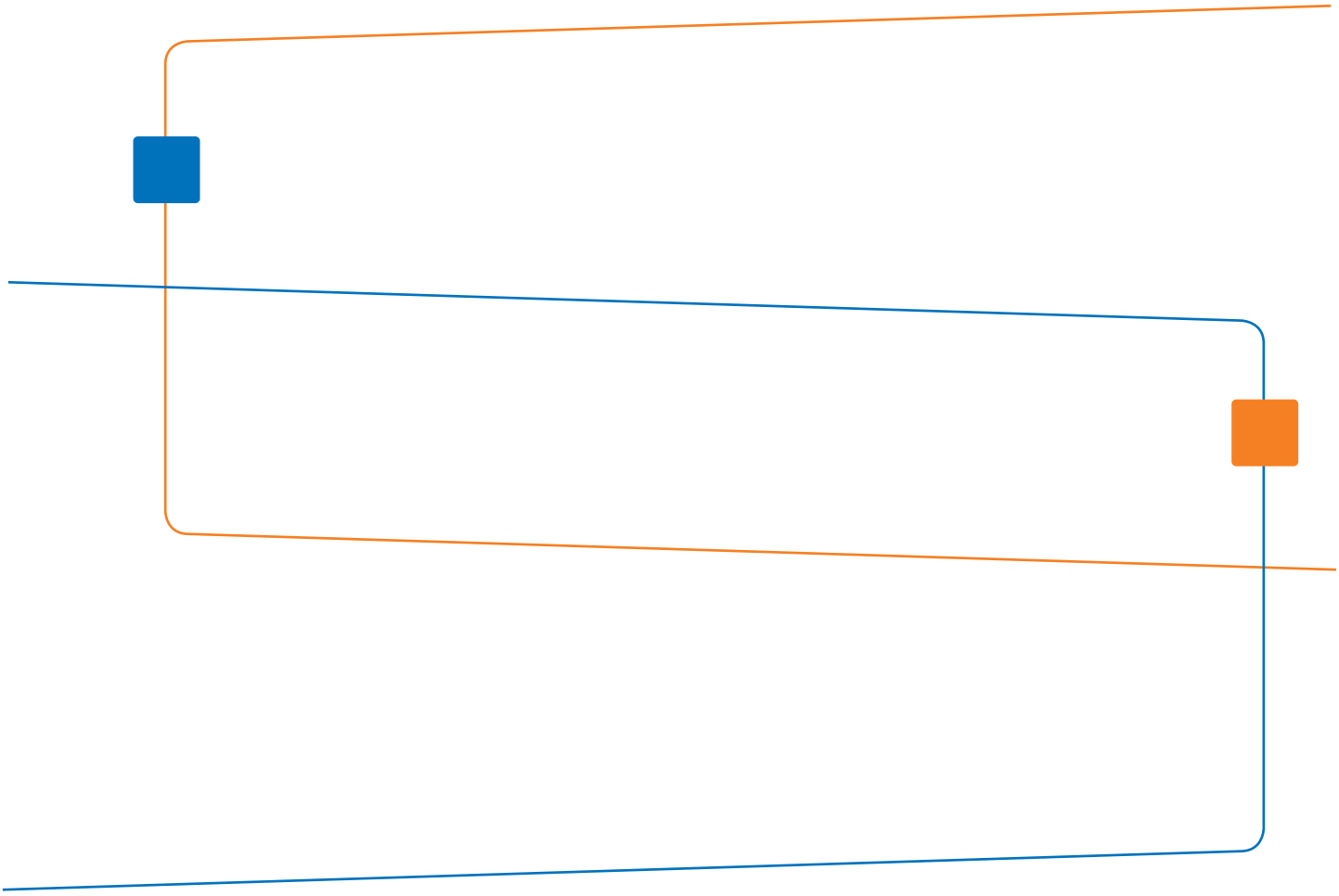
We're here for you

When you become a member, you can get your questions answered in the way that works best for you.

- **By phone:** Call the Member Services number on your mobile ID card.
- **Online:** Register at **anthem.com** or download the Anthem Anywhere mobile app to chat with a team member.

Your plan details

In this next section, you'll find more information about your plan.



The ins and outs of coverage

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

But part of your decision in choosing a plan also means you need to understand:

- Who can enroll
- How you and your employer handle coverage changes
- What's not covered by your plan
- How your coverage works with other health plans you might have

Who can be enrolled

You can choose coverage for just you. Or, you can have coverage for your family, including you and any of the following family members:

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

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

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

The ins and outs of coverage

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1. At the employer level, which affects you and other employees covered by an employer's plan, your plan can be:

Renewed	Canceled	Changed	When
●			Your employer: ○ Keeps its status as an employer. ○ Stays in our service area. ○ Meets our guidelines for employee participation and premium contribution. ○ Pays the required health care premiums. ○ Doesn't commit fraud or misrepresent itself.
	●		Your employer: ○ Makes a bad payment. ○ Voluntarily cancels coverage (30-days advance written notice required). ○ Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan. ○ Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	●		○ We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice). ○ We decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		●	You and your employer received a 30-day advance written notice that the coverage was being changed (services were added to your plan or the copays were lowered). Copays can be increased or services can be decreased only when it is time for your group to renew its coverage.

2. At the individual level, which affects you and covered family members, your plan can be:

Renewed	Canceled	When you
●		○ Stay eligible for your employer's coverage. ○ Pay your share of the monthly payment (premium) for coverage. ○ Don't commit fraud or misrepresent yourself.
	●	Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.
	●	○ Lose your eligibility for coverage. ○ Don't make required payments or make bad payments. ○ Commit fraud. ○ Are guilty of gross misbehavior. ○ Don't cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries). ○ Let others use your ID card. ○ Use another member's ID card. ○ File false claims with us. Your coverage will be canceled after you receive a written notice from us.

The ins and outs of coverage

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Special enrollment periods

In most cases, you're only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it's first offered to you as a "new hire" or during your employer's open enrollment period, when employees can make changes to their benefits for an upcoming year.

But there can be other times when you may be eligible to enroll. For example, let's say the first time you were offered coverage, you stated in writing that you didn't want to enroll yourself, your spouse or your covered dependents because you had coverage through another carrier or group health plan. If you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) you may be able to enroll your family later. But you must ask to be enrolled within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Also, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Finally, a special enrollment period of 60 days will be allowed if:

- Your or your dependents' coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility.
- You or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan.

To request special enrollment or get more information, contact your employer.

When you're covered by more than one plan

If you're covered by two different group health plans, one is considered primary and the other is considered secondary. The primary plan is the first to pay a claim and reimburse according to plan allowances. The secondary plan then reimburses, usually covering the remaining allowable costs.

The ins and outs of coverage

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Determining the primary and secondary plans

See the chart below to learn which health plan is considered the primary plan. The term "participant" means the person who signed up for coverage:

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

The ins and outs of coverage

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How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

If health care benefits are overpaid by mistake, we will ask for reimbursement for the overpayment. This is referred to as "coordination of benefits recoveries." We appreciate your help in the recovery process. We reserve the right to recover any overpayment from:

- Any person to or for whom the overpayments were made
- Any health care company
- Any other organization

The ins and outs of coverage

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

Acts of war, disasters or nuclear accidents

In the event of a major disaster, epidemic, war or other event beyond our control, we will make a good faith effort to give you covered services. We will not be responsible for any delay or failure to give services due to lack of available facilities or staff. Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot or civil disobedience.

Administrative charges:

- Charges to complete claim forms.
- Charges to get medical records or reports.
- Membership, administrative or access fees charged by doctors or other providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

Alternative/complementary medicine:

Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

- Acupuncture
- Holistic medicine
- Homeopathic medicine
- Hypnosis
- Aroma therapy
- Massage and massage therapy
- Reiki therapy
- Herbal, vitamin or dietary products or therapies
- Naturopathy
- Thermography
- Orthomolecular therapy
- Contact reflex analysis
- Bioenergetic synchronization technique (BEST)
- Iridology— study of the iris
- Auditory integration therapy (AIT)
- Colonic irrigation
- Magnetic innervation therapy
- Electromagnetic therapy
- Neurofeedback/Biofeedback

Applied behavioral treatment (including but not limited to applied behavior analysis and intensive behavior interventions) unless otherwise required by law.

Before effective date or after termination date

Charges for care you get before your effective date or after your coverage ends, except as written in this plan.

Certain providers

Services from providers that are not licensed by law to provide covered services. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians and athletic trainers.

Charges over the maximum allowed amount

Charges over the maximum allowed amount for covered services.

Charges not supported by medical records

Charges for services not described in your medical records

The ins and outs of coverage

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Clinically equivalent alternatives

Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. Clinically equivalent means drugs that for most members will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please visit our website at **anthem.com**.

If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

Complications of or services related to noncovered services

Services, supplies or treatment related to or for problems directly related to a service that is not covered by this plan. Directly related means that the care took place as a direct result of the noncovered service and would not have taken place without the noncovered service.

Contraceptives

Contraceptive devices including diaphgrams, intrauterine devices (IUDs) and implants (for employers who qualify to opt out of this benefit).

Cosmetic services:

- Treatments, services, prescription drugs, equipment or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
- This exclusion does not apply to surgery or procedures:
  - To correct deformity caused by disease, trauma or previous therapeutic process.
  - To correct congenital abnormalities that cause functional impairment.
  - On newborn children to correct congenital abnormalities.

Court-ordered testing

Court-ordered testing or care unless medically necessary.

Custodial care

Custodial care, convalescent care or rest cures. This exclusion does not apply to hospice services.

Delivery charges

Charges for delivery of prescription drugs.

Dental exclusions:

- Dental care for members age 19 and older unless covered by the medical benefits of this plan.
- Dental services or health care services not specifically listed as covered (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this plan).
- Services of anesthesiologists, unless covered by law.
- Intravenous and nonintravenous conscious sedation, analgesia and general anesthesia are not covered when given separate from a complex surgical service except when required by law.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of your teeth when your tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

The ins and outs of coverage

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- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the plan. The exception to this exclusion is root canal retreatment as described in *Endodontic Therapy* in the *What is Covered* section of the post-enrollment *Evidence of Coverage* or *Member Booklet*.
- Bacteriologic tests for determining periodontal disease or pathologic agents, unless covered by the medical benefits of this plan.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Collection of oral cytology sample via scraping of the oral mucosa, unless covered by the medical benefits of this plan.
- Services billed separately when they are a main part of another covered service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Incomplete services where the final permanent appliance (dental, partial, bridge) or restoration (crown, filling) has not been placed.
- Additional, elective or enhanced prosthodontic procedures including, but not limited to: connector bar(s), stress breakers and precision attachments.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure (such as a filling).
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.
- Removal of pulp debridement, pulp cap, post pin(s), resorbable or nonresorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (tooth root).
- Root canal construction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Dental services received prior to the effective date of the plan or received after the plan coverage has ended.
- Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
- Implant services, including maintenance or repair to an implant or implant abutment.
- Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
- Any condition, disease, defect, ailment or injury arising from or during employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

Drugs contrary to approved medical and professional standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

Drugs over quantity or age limits which are over any quantity or age limits set by your coverage or by us.

Drugs over the quantity prescribed or refills after one year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription order.

Drugs prescribed by providers lacking qualifications, registrations or certifications. Prescription drugs prescribed by a provider who does not have the necessary qualifications, registrations or certifications, as determined by us.

The ins and outs of coverage

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Drugs that do not need a prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law) except for injectable insulin.

Educational services

Services or supplies for teaching, vocational or self-training purposes, except as otherwise listed as covered.

Experimental or investigational services

Services or supplies that we find are experimental/investigational. This also applies to services related to experimental/investigational whether you get them before, during, or after you get the experimental/investigational service or supply. The fact that a service or supply is the only available treatment will not make it a covered service if we conclude it is experimental/investigational. Please see the "clinical trials" section of "what's covered" in the post enrollment *Evidence of Coverage* or *Member Booklet* for details about coverage for services given to you as a participant in an approved clinical trial if the services are covered services under this plan.

Eyeglasses and contact lenses

Eyeglasses and contact lenses to correct your eyesight unless listed as covered. This exclusion does not apply to lenses needed after a covered eye surgery or accidental injury.

Eye exercises

Orthoptics and vision therapy

Eye surgery

Eye surgery to fix errors of refraction, such as nearsightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis and excimer laser refractive keratectomy.

Family members

Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.

Foot care

Routine foot care unless medically necessary. This exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including, but not limited to:

- Cleaning and soaking the feet.
- Applying skin creams to care for skin tone.
- Other services that are given when there is not an illness, injury or symptom involving the foot.

This exclusion does not apply to the treatment of corns, calluses and care of toenails for members with diabetes or vascular disease.

Is a treatment considered experimental?

Many of our medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage.

To be approved for coverage, the service or product must have:

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

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Foot orthotics

Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

Foot surgery

Surgical treatment of flat feet; subluxation of the foot; weak, strained or unstable feet; tarsalgia; metatarsalgia or hyperkeratoses.

Free care

Services you would not have to pay for if you didn't have this plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from workers' compensation and services from free clinics. If workers' compensation benefits are not available to you, this exclusion does not apply. This exclusion will apply if you get the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation and whether or not you get payments from any third party.

Gene therapy

Gene therapy as well as any drugs, procedures and health care services related to it that introduce or are related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Health club memberships and fitness services

Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment or facilities used for physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

Hearing aids

Hearing aids or exams to prescribe or fit hearing aids. This exclusion does not apply to cochlear implants.

Home care

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home health care provider.
- Food, housing, homemaker services and home delivered meals. The exception to this is homemaker services as described under *Hospice Care* in the *What's Covered* section of the post-enrollment *Evidence of Coverage* or *Member Booklet*.

Infertility treatment

Treatment related to infertility, except as outlined in the *Maternity and Reproductive Health* subsection in the *What's Covered* section of the post-enrollment *Evidence of Coverage* or *Member Booklet*.

Lost or stolen drugs

Refills of lost or stolen drugs.

Maintenance therapy

Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This exclusion does not apply to habilitative services.

Medical equipment, devices and supplies:

- Replacement or repair of purchased or rental equipment because of misuse, abuse or loss or theft.
- Surgical supports, corsets or articles of clothing unless needed to recover from surgery or injury.
- Nonmedically necessary enhancements to standard equipment and devices.
- Supplies, equipment and appliances that include comfort, luxury or convenience items or features that exceed what is medically necessary in your situation. Reimbursement will be based on the maximum allowable amount for a standard item that is a covered service, serves the same purpose and is medically necessary. Any expense that exceeds the maximum allowable amount for the standard item which is a covered service is your responsibility.

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Medicare

Services for which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B when you become eligible due to age, except as required by the federal law. If you did not enroll in Medicare Part B, when you became eligible due to age, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out-of-pocket costs.

Missed or canceled appointments

Charges for missed or canceled appointments.

Nonmedically necessary services

Services we conclude are not medically necessary. This includes services that do not meet our medical policy, clinical coverage or benefit policy guidelines.

Nutritional or dietary supplements

Nutritional and/or dietary supplements, except that we must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.

Off label use

Off label use, unless we must cover it by law or if we approve it.

Oral surgery

Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth.

Personal care and convenience:

- Items for personal comfort, convenience, protection or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats and shower chairs.
- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, nonsterile gloves or heating pads).
- Home workout or therapy equipment, including treadmills and home gyms.
- Pools, whirlpools, spas or hydrotherapy equipment.
- Hypoallergenic pillows, mattresses or waterbeds.
- Residential, auto or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment or handrails).

Private-duty nursing

Private-duty nursing services. Your coverage does not include benefits for private-duty nurses in the inpatient setting.

Prosthetics

Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics. The exception to this exclusion is wigs needed after cancer treatment as described in the *Prosthetic and Medical and Surgical Supplies* in the *What's Covered* section of the post-enrollment *Evidence of Coverage* or *Member Booklet*.

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Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house or school because a member's own home arrangements are not available or are unsuitable and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled or outward bound programs, even if psychotherapy is included.
- Wilderness camps.

Routine physicals and immunizations

Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment for licensing, sports programs or for other purposes, which are not required under law.

Sexual dysfunction

Services or supplies for male or female sexual problems.

Stand-by charges

Stand-by charges of a doctor or other provider.

Reversal of elective sterilization (for employer groups who qualify to opt out).

Sterilization for females (for employer groups who qualify to opt out).

Surrogate mother services

Services or supplies for a person not covered under this plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Telemedicine

Noninteractive telemedicine services, such as audio-only telephone conversations, email messages, faxes or online questionnaires.

Temporomandibular joint treatment

Fixed or removable appliances that move or reposition the teeth, fillings or prosthetics (crowns, bridges, dentures).

Travel costs

Mileage, lodging, meals and other member-related travel costs.

Vein treatment

Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

Vision services:

- Eyeglass lenses, frames or contact lenses for members age 19 and older, unless listed as covered.
- Safety glasses and accompanying frames.
- For two pairs of glasses instead of bifocals.
- Plano lenses (lenses that have no refractive power).
- Lost or broken lenses or frames, unless the member has already reached their normal interval for service when seeking replacements.
- Vision services not listed as covered in this booklet.
- Cosmetic lenses or options such as special lens coatings or non-prescription lenses, unless specifically listed as covered.
- Blended lenses.

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- Oversize lenses.
- Sunglasses and accompanying frames.
- For services or supplies combined with any other offer, coupon or in-store advertisement or for certain brands of frames where the manufacturer does not allow discounts.
- For vision services for pediatric members, no benefits are available for frames or contact lenses not on the Anthem formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.

Waived cost shares out of network

Your coverage does not include waived cost shares out of plan. For any service in which you are responsible under the terms of this plan to pay a copay, coinsurance or deductible and the copay, coinsurance or deductible is waived by an out-of-network provider.

Weight-loss programs

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

Weight-loss surgery bariatric surgery

This includes, but is not limited to, Roux-en-Y (RNY) laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries that lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or gastroplasty (surgeries that reduce stomach size) or gastric banding procedures.

Prescription benefit exclusions:

Certain items are not covered under the prescription drug retail or home delivery (mail service) pharmacy benefit.

- **Administration charges:**
  - Charges for the administration of any drug except for covered immunizations as approved by us or the pharmacy benefits manager (PBM).
- **Charges not supported by medical records.** Charges for pharmacy services not related to conditions, diagnoses and/or recommended medications described in your medical records.
- **Compound drugs:**
  - Compound drugs unless all of the ingredients are FDA-approved as designated in the FDA's *Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations* and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA-approved compound ingredients may include multisource, nonproprietary vehicles and/or pharmaceutical adjuvants.
- **Contraceptives, injectable drugs and patches** unless we must cover them by law (this exclusion only applies if employer group has qualified to opt out of this coverage).
- **Contrary to approved medical and professional standards:**
  - Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Delivery charges:**
  - Charges for delivery of prescription drugs.
- **Drugs given at the provider's office or facility:**
  - Drugs you take at the time and place where you are given them or where the prescription order is issued. This includes samples given by a doctor. This exclusion does not apply to drugs used with a diagnostic service, drugs given during chemotherapy in the office or drugs covered under the *Medical and Surgical Supplies* benefit — they are covered services.

The ins and outs of coverage

(continued)

- **Drugs not on the Anthem prescription drug list (a formulary)**:
  - You can get a copy of the list by calling us or visiting our website at **anthem.com**. If you or your doctor believes you need a certain prescription drug not on the list, please refer to the *Prescription drug benefit at a retail or home delivery (mail service) pharmacy* section of your post enrollment *Evidence of Coverage* (Anthem HealthKeepers members) or *Member Booklet* (all other members) for details about requesting an exception.
- **Drugs that do not need a prescription:**
  - Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- **Drugs prescribed by providers lacking qualifications/ registrations/certifications.**
  - Prescription drugs prescribed by providers that do not have the necessary qualifications, registrations and/or certifications as determined by us.
- **Drugs over quantity or age limits:**
  - Drugs in quantities which are over the limits set by the plan, or which are over any age limits set by us.
- **Drugs over the quantity prescribed or refills after one year:**
  - Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
- **Family members:**
  - Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.
- **Gene therapy:**
  - Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- **Infertility drugs:**
  - Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- **Items covered as durable medical equipment (DME):**
  - Therapeutic DME, devices and supplies except peak-flow meters, spacers and blood glucose monitors. Items not covered under the *Prescription drug benefit at a retail or home delivery (mail service) pharmacy* benefit may be covered under the *Durable Medical Equipment and Medical Devices* benefit.
- **Items covered under the "Allergy Services" benefit:**
  - Allergy desensitization products or allergy serum. While not covered under the *Prescription drug benefit at a retail or home delivery (mail service) pharmacy* benefit, these items may be covered under the " Allergy Services" benefit.
- **Lost or stolen drugs:**
  - Refills of lost or stolen drugs.
- **Mail order providers other than the PBM's home delivery provider:**
  - Prescription drugs dispensed by any home delivery provider other than the PBM's home delivery provider, unless we must cover them by law.
- **Non-approved drugs.** Drugs not approved by the FDA.

Non-medically necessary services

Services we conclude are not medically necessary. These include services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

Nutritional or dietary supplements.

Nutritional and/or dietary supplements, except what we must cover by law. This exclusion includes, but is not limited to: nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription from a licensed pharmacist.

The ins and outs of coverage

(continued)

Off label use.

Off label use, unless we must cover it by law or if we or the PBM approve it. The exception to this exclusion is described in the "covered prescription drugs" in the *Prescription drug benefit at a retail or home delivery (mail service) pharmacy* section of the post enrollment *Evidence of Coverage* or *Member Booklet*.

Onychomycosis drugs

Drugs for onchomycosis (toenail fungus) except when we allow it to treat members who are immune-compromised or diabetic.

Over-the-counter items

Drugs, devices and products permitted to be dispensed without a prescription and available over the counter. This exclusion does not apply to over the counter products that we must cover as a preventive care benefit under federal law with a prescription.

Sexual dysfunction drugs

Drugs to treat sexual or erectile problems.

Syringes

Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.

Weight loss drugs

Any drug mainly used for weight loss.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
.ةدعاسملاكبطخلا فيعتلا ةقطبيعل دوجوملا ءاضعألا ةمدخ مقربلصتا.اًجم كعفنلقدعاسملاو تامولعملاهذه ىلعلوصحلاكلقحي
)TTY/TDD: 711(

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Let's talk about your privacy and rights

Safeguarding your information

As a member, you have the right to expect us to protect the privacy of your personal health information. We do this according to state and federal laws, and our policies. You also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to **www.anthem.com/memberrights**. To ask for a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). Doctors and pharmacists who want to be sure you get the best treatments for certain health conditions make up Anthem's UM team. They review the information your doctor sends us. These reviews can be done before, during or after your treatment. We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more detailed information about how we help manage your care, visit **www.anthem.com/memberrights**.To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Notes

Notes

We've got your back!

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

These policies have exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for Anthem HealthKeepers plans. AHK-VA-HMOPOS-EOC (1/18), AHK-VA-HMOPOS-SOB-RVA2fB1 (1/18), AHK-VA-HMOPOS-SOB-RVA2fG4 (1/18), AHK-VA-HMOPOS-SOB-RVA2fS4 (1/18), AHK-VA-HMOPOS-SOB-RVA2fS6 (1/18), AHK-VA-HMOPOS-SOB-RVA2fS7 (1/18), AHK-VA-HMOPOS-SOB-TVA1G17 (1/18), AHK-VA-HMOPOS-SOB-TVA1G3 (1/18), AHK-VA-HMOPOS-SOB-TVA1G5 (1/18), AHK-VA-HMOPOS-SOB-TVA1P1 (1/18), AHK-VA-HMOPOS-SOB-TVA2iG1-rxA (1/18), AHK-VA-HMOPOS-SOB-TVA2iG2-rxA (1/18), AHK-VA-HMOPOS-SOB-TVA2iS2-rxA (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG11 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG38 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG63 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG64 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG65 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RS5 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RS15 (1/18), AHK-VA-HMOPOS-SOB-TVA3B4-HSA (1/18), AHK-VA-HMOPOS-SOB-TVA3G1-rxF (1/18), AHK-VA-HMOPOS-SOB-TVA3G4-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA3G7-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA3iB1-HSA-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA3iS2-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA3S2-HSA-rxC-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA3S3O-HSA (1/18), AHK-VA-HMOPOS-SOB-TVA3S3-HSA-rxC-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA3S6-HSA-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA1G4 (1/18), AHK-VA-HMOPOS-SOB-TVA1G6 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG301 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG73 (1/18), AHK-VA-HMOPOS-SOB-TVA2-RG74 (1/18), AHK-VA-HMOPOS-SOB-TVA3B1-HSA-PrevRx (1/18), AHK-VA-HMOPOS-SOB-TVA3S7-HSA-PRevRx (1/18). If you have questions, please contact your agent, Group Administrator, or member services: Enrollment applications used for Anthem HealthKeepers: 37612VAMENABS (1/17) This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031 Life and Disability products underwritten by Anthem Life Insurance. HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.