Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

A guide to choosing your health plan

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

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An ID card means something

It means you have access to quality care from quality doctors. It means you can always get your questions answered. It means you have our support before you ever need health care. And that's what this guide is for. We want you to have everything you need to make a good decision.

We're also giving you a personalized Enrollment Resource webpage where you can:

- Watch an interactive video with helpful tips on selecting a plan.
- View and save a digital version of this guide.
- Find a doctor in your network.
- View your full plan details.

View your enrollment resources at http://enrollment.anthem.com/PrintOnlyABCBS.

Frequently asked questions (FAQs)

You can register at anthem.com – your simple and convenient solution to managing your health

How do I use my health plan when I need care?

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor.

Can I manage my health care on the Web?

Yes. As soon as you become a member, you'll be able to register at anthem.com. It's designed to help you manage your health care and your coverage simply and conveniently. Many of our members find these self-service tools helpful:

- Check on your claims.
- Find a doctor.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.

Download the free anthem.com mobile app so you can manage your health care on the go!

Visit **anthem.com/guidedtour** to watch a video explaining how our website can help you.

How can my plan help me save money?

You'll save money every time you go to a doctor in network — they've agreed to charge lower rates for members. But we'll also help save you money before you go to the doctor.

At anthem.com, you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products.

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 requires understanding:

- Who can be enrolled.
- How coverage changes are handled.
- What's not covered by your plan.
- How your plan works with other coverage.

Who can be enrolled

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

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

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

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

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

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

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

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

The ins and outs of coverage

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Special enrollment periods

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

When you're covered by multiple plans

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

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

The ins and outs of coverage

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Determining the primary versus secondary carrier

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

When a person is covered by 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 stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	●	
	The non-custodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

The ins and outs of coverage

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How benefits apply when Medicare-eligible

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

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

Recovery of overpayments

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

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

The ins and outs of coverage

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The following services and supplies will not be covered under your Anthem HealthKeepers plan offered by HealthKeepers, Inc.

What's not covered (exclusions)

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

Acupuncture

Services not **authorized in advance** by us and prearranged by your primary care physician, unless otherwise specified in this book.

Biofeedback therapy

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

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

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 unless you submitted a treatment plan to us for prior approval. No approval of a plan of treatment by us is required for emergency treatment of a dental injury.
- Biting and chewing related injuries unless the chewing or biting results from a medical or mental condition.
- Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth.
- Extraction of either erupted or impacted wisdom teeth.
- Anesthesia and hospitalization for dental procedures and services except as specified as otherwise being covered.

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

Educational, vocational or self management training purposes, except as otherwise specified as being covered or when received as part of covered preventive care.

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

Experimental ... or not?

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 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.

The ins and outs of coverage

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Family planning

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

Services for palliative or cosmetic **foot** care

- Flat foot conditions
- Support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- Foot orthotics
- Subluxations of the foot
- Corns, calluses and care of toenails (except in treatment for patients with diabetes or vascular disease)
- Bunions (except capsular or bone surgery)
- Fallen arches, weak feet, chronic foot strain
- Symptomatic complaints of the feet

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

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

Hearing aids or for examinations to prescribe or fit hearing aids, except for cochlear implants, are not covered.

Home care services

- Homemaker services (except as rendered as part of Hospice care)
- Maintenance therapy
- Food and home-delivered meals
- Custodial care and services

Hospital services

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

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

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

- Exercise equipment
- Air conditioners, dehumidifiers, humidifiers, and purifiers
- Hypoallergenic bed linens
- Whirlpool® baths
- Handrails, ramps, elevators, and stair glides
- Telephones
- Adjustments made to a vehicle
- Foot orthotics
- Changes made to a home or place of business
- Repair or replacement of equipment you lose or damage through neglect

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

Services or supplies deemed not **medically necessary** as determined by us at our sole discretion. Notwithstanding this exclusion, all preventive care services and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by us 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

The ins and outs of coverage

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inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal our decision that a service is not medically necessary.

Mental health and substance use

- Inpatient stays for environmental changes
- Cognitive rehabilitation therapy
- Educational therapy
- Vocational and recreational activities
- Coma stimulation therapy
- Services for sexual deviation and dysfunction
- Treatment of social maladjustment without signs of a psychiatric disorder
- Remedial or special education services

Nutrition counseling and related services, except when provided as part of diabetes education, mental health treatment of an eating disorder or when received as part of a covered preventive care services visit or screening.

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

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

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

Paternity testing

Prescription drug benefits

- Administrative charges: Charges for the administration of any drug except for covered immunizations as approved by us or the Pharmacy Benefits Manager.
- Compound drugs: Compound drugs unless all of the ingredients are FDA-approved 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 multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- 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/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 the doctor. This exclusion does not apply to drugs used with diagnostic services, drugs used during chemotherapy in the office, or drugs covered under the medical supplied benefit; those would be covered services.
- Drugs not on the Anthem prescription drug list (a formulary): You can get a copy of this list by calling us or visiting us at anthem.com. If you or your doctor believes you need a certain prescription drug not on the list, please refer to the

The ins and outs of coverage

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"prescription drug benefits at a retail or home delivery (mail order) pharmacy" section in your post enrollment *Evidence of Coverage* for details on 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.
- Drugs over the 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 a refill given more than one year after the date of the original prescription order.
- Infertility treatments: 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 drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit may be covered under the medical equipment (durable) or medical supplies benefit.
- Items covered the medical supplies and medications benefit: Allergy desensitization products or allergy serum. While not covered under the "prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy" benefit, these items may be covered under the medical supplies and medications benefit.
- Mail-order providers other than our home delivery mail-order provider: Prescription drugs dispensed by any mail order provider other than our mail order provider unless we must cover them by law.
- Non-approved drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless we must cover the use by law or if we, or the Pharmacy Benefits Manager, approve it.
- Onychomycosis drugs: Drugs for Onchomycosis (tonail fungus), except when we allow it to treat members who are immuno-compromised or diabetic.
- Over-the-counter items: Drugs, devices and products, or prescription legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device or product. This includes prescription legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over the counter products that we must cover under federal law with a prescription.
- Sex change drugs: Drugs for sex change surgery.
- Sexual dysfunction drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodemic 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. 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.

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

Services or supplies or devices:

- Not listed as covered under your health plan
- Not prescribed, performed, or directed by a provider licensed to do so.
- Received before the effective date or after a covered person's coverage ends.
- Services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- Benefits for charges from stand-by physicians in the absence of covered services being rendered.
- Telephone consultations, charges for not keeping appointments, or charges for completing claim forms.

Services or supplies if provided or available to a member:

- Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the

The ins and outs of coverage

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secondary payor after benefits under this plan have been paid.

- Provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government.

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

- Amounts above the allowable charge for a service
- Neurofeedback, and related diagnostic tests
- Penile implants

Services or supplies if they are received from providers not licensed by law to provide services. Examples include masseurs (massage therapists), physical therapist technicians and athletic trainers.

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

Skilled nursing facility stays

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

Smoking cessation programs not affiliated with us

Spinal manipulation and manual medical therapy services (chiropractic care).

- Any treatment or service not authorized by American Specialty Health Group (ASHG)
- Any service or treatment not provided by an ASHG provider (this exclusion does not apply to Point of Service plans)
- Nonneuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment
- Laboratory tests, X-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate or classified as experimental/investigative or in the research stage
- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning, thermography
- Educational programs, non-medical self-care and or self-help, or any self-help physical exercise training
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any similar devices or appliances
- Vitamins, mineral, nutritional supplements or any other similar type product

Telemedicine

Non-interactive telemedicine services, including audio-only telephone, electronic mail message, facsimile transmissions or online questionnaire.

Therapies

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

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

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Vision services

- For members through age 18, there is no benefit for frames or contact lenses purchased outside of our formulary.
- Vision services or supplies, unless needed due to eye surgery and accidental injury
- Routine vision care and materials
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure
- Services for vision training and orthoptics
- Tests associated with the fitting of contact lenses, unless the contact lenses are needed due to eye surgery or to treat accidental injury
- Sunglasses or safety glasses and accompanying frames of any type
- Any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- Any lost or broken lenses or frames
- Cosmetic lens options that are not otherwise specifically listed as covered.
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- Any other vision services not specifically listed as covered

Waived cost shares

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 copayment, coinsurance or deductible, and the copayment coinsurance or deductible is waived by an out-of-network provider.

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

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

How we protect our members

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And 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.

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). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

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 about how we help manage your care, visit www.anthem.com/memberrights.

Special Enrollment Rights

There are certain situations when you can enroll in a plan outside the open enrollment period. Open enrollment usually happens only once a year. That's the time you can enroll in a plan or make changes to it. If you choose not to enroll during open enrollment, there are special cases when you're allowed to enroll yourself and your dependents. Special enrollment is allowed:

- ***If you had another health plan that was canceled.*** If you, your dependents or your spouse are no longer eligible for other coverage (or if the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it).
  - For example: You and your family are enrolled through your spouse's coverage at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in a plan.
- ***If you have a new dependent.*** This could mean a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- ***If your eligibility for Medicaid or SCHIP changes.*** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or CHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.

Notes

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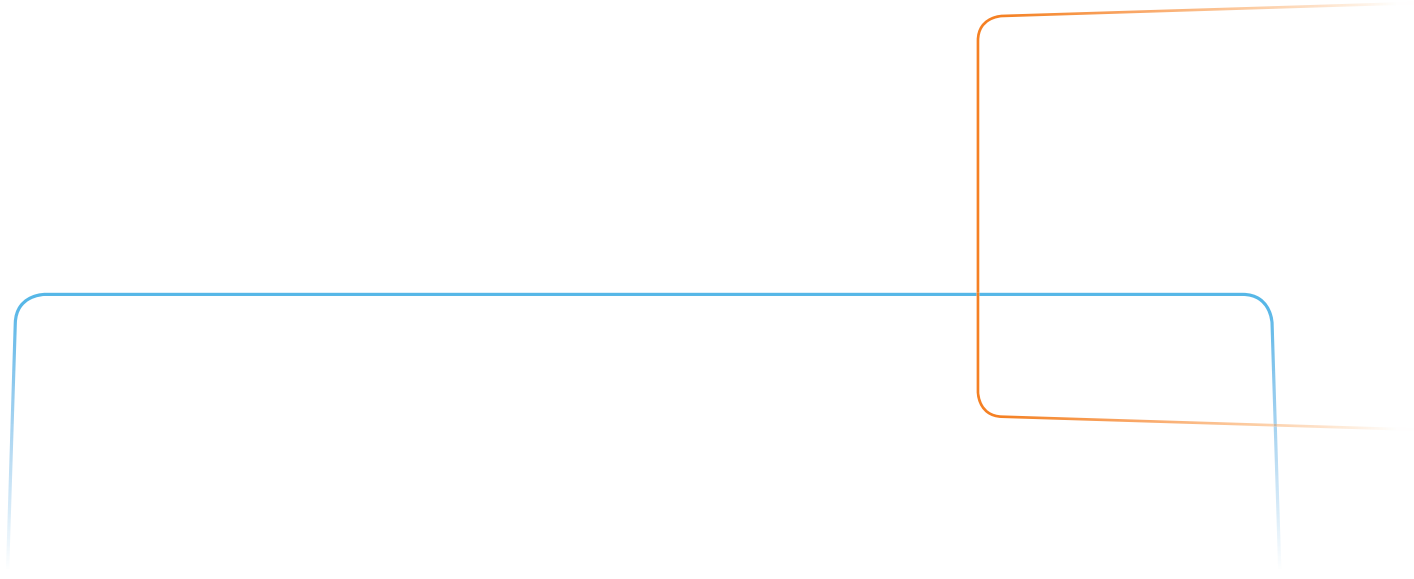

Carry an ID card that means something. **Enroll now.**

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for Anthem HealthKeepers plans. If you have questions, please contact your agent, Group Administrator, or member services: H-INTRO-HK (7/13), H-TOC (1/15), H-SB-HMO (1/16), H-SB-POS (1/16), H-SB-LUM (1/16), H-WORKS-HK (1/16), H-COVERED-HK (1/16), H-EXCL (1/16), H-CLAIMS-HK (1/16), H-ENR (1/15), H-COB (1/16), H-INFO-HK (1/16), H-RIGHTS (1/16), H-DEF-HK (4/16), H-EXH-A (1/16), H-INDEX (1/14), H-ENDS (1/15) Enrollment applications used for Anthem HealthKeepers: 490773 (1/15) 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. 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. Life and Disability products underwritten by Anthem Life Insurance.

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