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KeyCare Plan

Take Control of Your Health

Your Anthem Plan

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Anthem Blue Cross and Blue Shield KeyCare 10 Member Certificate

This member booklet fully explains your health care benefits and how *you* can maximize them. 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.

Important phone numbers

Member Services
804- 358- 1551
in Richmond
800- 451- 1527
from outside Richmond

How to obtain language assistance

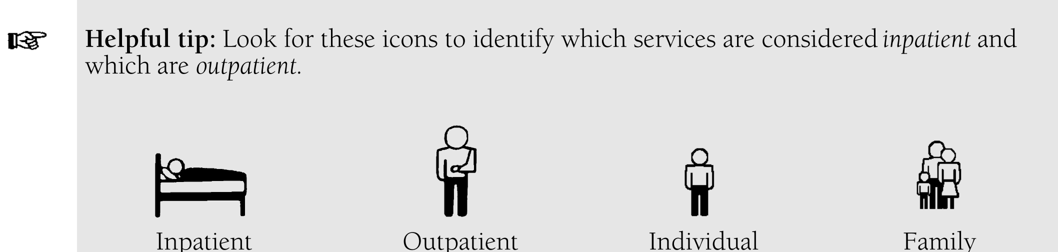
Anthem is committed to communicating with *our* members about their health plan, regardless of their language. *Anthem* employs a Language Line interpretation service for use by all of *our* Member Services Call Centers. Simply call the Member Services phone number on the back of your ID card and a representative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

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. ET
Saturday
9:00 a.m. to 1:00 p.m. ET

Visit us on- line at:
www.anthem.com



Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.

Key words

There are a few key words *you* will see repeated throughout this booklet. *We've* highlighted them here to make the booklet easier to understand. In addition, *we* have included a **Definitions** section on page 76 that lists the various words referenced. A defined word will be italicized each time it is used.

We, us, our, Anthem
Anthem Blue Cross and Blue Shield.

Covered persons
You and enrolled eligible dependents.

Outpatient
When you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

Inpatient
When you are a bed patient in the hospital.

You
The enrolled employee.

Your health plan
Anthem KeyCare plan.

Copayment
The fixed dollar amount you pay for some covered services.

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

Table of contents

page

Summary of benefits 1

How your health plan works 5

Covered providers and facilities 5

Hospital Admission Review 10

If you have a pre- existing condition 13

What is covered 15

What is not covered (Exclusions) 35

Claims and payments 43

What you will pay 43

When you must file a claim 49

When you are covered by more than one health plan 52

Coordination of Benefits 52

Medicare Carve- out 53

Changing your coverage 55

Who is eligible for coverage 55

When you may enroll 56

If your family changes 57

After coverage ends 59

After you become eligible for Medicare 59

Continuation of coverage (COBRA) 60

Important Information about your health plan 64

Complaint and appeal process 65

Member's rights and responsibilities 74

Definitions 76

Exhibit A 83
Experimental/investigative criteria 83
Clinical trial costs 84
Index 85
Special features and programs 87
360° Health Program 87
Vision Program 90

Summary of benefits

This chart is an overview of your benefits for covered services. They are listed in detail beginning on page 15. A list of services that are not covered begins on page 35.

What will I pay?

This chart shows the most you pay for deductibles and out- of- pocket expenses for covered services in one year of coverage. Please see the Out- of- network care paragraph on page 8 for more information about amounts above the *maximum allowed amount* when services are received from non- participating providers.

	In- network		Out- of- network		Detail Page number
	Individual	Family	Individual	Family	
Calendar year deductible	$0	$0	$200	$400	43
The most you will pay per calendar year	$1,500	$3,000	$3,000	$6,000	43

	In- network		Out- of- network	Detail
	Copayment	Coinsurance	Coinsurance (after calendar year deductible)	Page number
Ambulance Travel	$100	0%	20% *	15
Autism services				
Applied behavior analysis $35,000 calendar year limit for applied behavior analysis	$0	20%	30%	15
All other services for autism	Copayment/coinsurance determined by service received			15
Dental services	$0	20%	30%	16
Diabetic equipment and education	$0	20%	30%	16
Diagnostic tests for specific conditions or diseases at a doctor's office, emergency room, or outpatient hospital department	$0	10%	30%	16
Dialysis treatments				
Facility	$0	10%	30%	17
Doctor's Office	$0	10%	30%	17
Doctor visits on an outpatient basis				
Primary Care Physicians	$10	0%	30%	17
Specialty Care Providers	$20	0%	30%	17
Early intervention services $5,000 calendar year limit. Limit does not apply to occupational, physical or speech therapy services.	Copayment/coinsurance determined by service received			18
Emergency room visits				
Facility services copayment waived if admitted	$150 *per visit*	10%	30%	18
Professional provider services	$0	10%	30%	18

* Services for out- of- network ambulance providers will be subject to the in- network deductible (if any) only.

	In- network		Out- of- network	Detail
	Copayment	Coinsurance	Coinsurance (after calendar year deductible)	Page number

Visits to an *out- of- network* emergency room for *emergency services* will be covered at in- network benefit levels and apply the in- network cost shares. The *facility* and *provider* may balance bill for any amounts in excess of the *maximum allowed amount.* The *out- of- network* benefit shown reflects the cost shares for *visits* to an *out- of- network* emergency room for services that are not *emergency services.*

	Copayment	Coinsurance	Out- of- network Coinsurance	Page number
Home care services 100- visit calendar year limit for home health services	$0	10%	30%	18
Home private duty nurses services $500 calendar year limit	$0	20%	**	19
Hospice care services	$0	0%	30%	19
Hospital services				
Inpatient treatment				
Facility services	$200 *per stay*	10%	30%	19
Professional provider services				
Primary Care Physicians	$0	10%	30%	19
Specialty Care Providers	$0	10%	30%	19
Outpatient treatment				
Facility services	$150 *per visit*	10%	30%	19
Professional provider services	$0	10%	30%	19
Infusion services - outpatient services ***				
Facility services	$0	10%	30%	20
Professional provider services	$0	10%	30%	20
Home services	$0	10%	30%	20
Infusion medications				
Outpatient settings	$0	20%	30%	20
Home settings	$0	10%	30%	20
Maternity				
Prenatal, postnatal and delivery See the What is covered section for additional information on copayments for prenatal and postnatal care	$150	0%	30%	20
Hospital services for delivery delivery room, anesthesia, nursing care for newborn	$200 *per stay*	10%	30%	20
Diagnostic tests	$0	10%	30%	20
Medical equipment (durable), prosthetics, appliances, formulas, supplies, and medications	$0	20%	30%	21
Mental health or substance abuse treatment				23
Inpatient treatment				23
Facility services	$200 *per stay*	10%	30%	23
Professional provider services	$0	10%	30%	23
Outpatient facility- based treatment (includes partial day)				23
Facility services	$0	10%	30%	23
Professional provider services	$0	10%	30%	23

** Since there is no network required for these services, benefits will be paid as if rendered on an in- network basis.
*** See Hospital services for payment amounts for inpatient therapy.

Summary of benefits continued

	In- network		Out- of- network	Detail
	Copayment	Coinsurance	Coinsurance (after calendar year deductible)	Page number
Outpatient office- based treatment	$10	0%	30%	23
Shots (injections) at a doctor's office, emergency room or outpatient hospital department	$0	10%	30%	29
Skilled nursing facility stays 100- day per stay limit				29
Facility services	$0	10%	30%	29
Professional provider services	$0	10%	30%	29
Spinal manipulations and other manual medical interventions 30 – visit calendar year limit per member				
Primary Care Physicians	$10	0%	30%	30
Specialty Care Providers	$20	0%	30%	30
Surgery				30
Inpatient treatment				
Facility services	$200 *per stay*	10%	30%	30
Professional provider services				
Primary Care Physicians	$0	10%	30%	30
Specialty Care Providers	$0	10%	30%	30
Outpatient treatment				
Facility services	$100 *per visit*	10%	30%	30
Professional provider services				
Primary Care Physicians	$10	0%	30%	30
Specialty Care Providers	$20	0%	30%	30
Therapy - outpatient services ***				
Cardiac rehabilitation therapy				
Hospital services	$0	10%	30%	32
Professional provider services	$0	10%	30%	32
Chemotherapy				
Hospital services	$0	10%	30%	32
Professional provider services	$0	10%	30%	32
Occupational therapy visits 30 – visit calendar year limit per member (combined with physical therapy visits). Limit does not apply to autism services.				
Hospital services	$20	10%	30%	32
Professional provider services				
Primary Care Physicians	$10	0%	30%	32
Specialty Care Providers	$20	0%	30%	32
Physical therapy visits 30 – visit calendar year limit per member (combined with occupational therapy visits). Limit does not apply to autism services.				
Hospital services	$20	10%	30%	32
Professional provider services				
Primary Care Physicians	$10	0%	30%	32
Specialty Care Providers	$20	0%	30%	32

*** See Hospital services for payment amounts for inpatient therapy.

Summary of benefits continued

	In- network		Out- of- network	Detail
	Copayment	Coinsurance	Coinsurance (after calendar year deductible)	Page number
Radiation therapy				
Hospital services	$0	10%	30%	32
Professional provider services	$0	10%	30%	32
Respiratory therapy				
Hospital services	$0	10%	30%	32
Professional provider services	$0	10%	30%	32
Speech therapy visits 30 – visit calendar year limit per member. Limit does not apply to autism services.				
Hospital services	$20	10%	30%	32
Professional provider services				
Primary Care Physicians	$10	0%	30%	32
Specialty Care Providers	$20	0%	30%	32
Vision correction after surgery or accident	$0	20%	30%	33
Wellness services for children and adults	$0	0%	30%	33

If wellness services are received from out- of- network providers, the services will be subject to the calendar year deductible. Screenings received for diagnostic purposes (as billed by the in or out- of- network provider or facility) are not considered to be wellness services, and therefore will also be subject to the diagnostic benefits shown earlier in the **Summary of benefits.**

	Copayment	Detail Page number
Prescription drugs and diabetic supplies		24
Retail pharmacy		24
covered drugs for up to a 30- day supply		
First tier	$8	24
Second tier	$15	24
Third tier	$30	24
Mail order pharmacy		26
covered drugs for up to a 90- day supply		
First tier	$8	26
Second tier	$30	26
Third tier	$90	26

	In- network		Out- of- network	Detail
	Copayment	Coinsurance	Payment allowance	Page number
Routine vision care one routine eye examination per calendar year	$15	0%	$30	28

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 health plan works

Your health plan provides a wide range of health care services within a special network of health care *providers* and *facilities*. *You* will receive benefits based on where *you* receive health care services and the limits stated in the Summary of benefits (see page 1) and related exclusions.

Carry your ID card

Your Anthem Blue Cross and Blue Shield ID card identifies *you* as a member and contains important health care coverage information. When *you* show your ID card to your doctor, hospital, pharmacist, or other health care *provider,* they will file your claims for *you* in most cases. Carrying your card at all times will ensure *you* always have this coverage information with *you* when *you* need it.

Covered providers and facilities

Your health plan covers certain care administered by *providers* and *facilities*. To ensure benefits, *providers* and *facilities* must be licensed in the state where they operate to perform the service *you* receive and the service must be covered by *your health plan*. Certain services are covered by the plan and rendered by other covered medical suppliers, such as suppliers of *medical equipment (durable),* private duty nursing services, *prescription drugs,* ambulance services, etc.

A *provider* may delegate to his employee the responsibility for performing a *covered service*. *Your health plan* will cover this care if *we* determine that a bona fide employer- employee relationship exists, based on information given by the *provider*. Under these circumstances:

- both the *provider* and the delegated employee must be licensed/certified to render the service;
- the service must be performed under the direct supervision of the *provider* since the *provider* is primarily responsible for the patient's care; and
- the *provider* who is directly supervising the service must bill for the service.

Because the service of the delegated employee is a substitute for the *provider's* service, *your health plan* will not pay a supervisory or other fee for the same service performed by both the *provider* and his delegated employee.

Primary care physicians and specialty care providers

Your health plan covers care provided by *primary care physicians* and *specialty care providers*. To see a *primary care physician,* simply visit any network physician who is a general or family practitioner, internist or pediatrician. *Your health plan* also covers care provided by any *specialty care provider you* choose. *Referrals* are never needed to visit any *specialty care provider*.

Choose a health care provider

In Virginia

You have the freedom to receive care from any *provider* or *facility*. However, *you* receive the highest level of benefits when *you* receive care from *providers* and *facilities* within the *KeyCare PPO Network*. Care received from *KeyCare PPO Network providers* and *facilities* is considered in-network care. Your policy provides coverage for certain services that do not have *providers* within *our* networks. These services would be considered in-network services. An example is private duty nursing services.

There is one exception. A member who is designated at the time of enrollment as a *Cost Awareness* person will receive the highest level of benefits for care received from any *provider* or *facility*, not just from *facilities* and *providers* within the *KeyCare PPO Network*. Care that a *Cost Awareness covered person* receives from any *provider* or *facility* (other than non-participating hospitals) is considered in-network care.

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

Out-of-area services

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever *you* obtain health care services outside of *our* service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between *us* and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside *our* service area, *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*. *Our* payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when *you* access covered health care services within the geographic area served by a Host Blue, *we* 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*.

Whenever *you* access covered health care services outside *our* service area and the claim is processed through the BlueCard Program, the amount *you* pay for covered health care services, 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 *us*.

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 *we* use 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.

Non- participating health care providers outside our service area

1. Member Liability Calculation
When covered health care services are provided outside of *our* service area by non- participating health care *providers,* the amount *you* pay for such services will generally be based on either the Host Blue's non- participating health care *provider* local payment or the pricing arrangements required by applicable state law. In these situations, *you* may be liable for the difference between the amount that the non- participating health care *provider* bills and the payment *we* will make for the *covered services* as set forth in this paragraph.

2. Exceptions
In certain situations, *we* may use other payment bases, such as billed covered charges, the payment *we* would make if the health care services had been obtained within *our* service area, or a special negotiated payment, as permitted under Inter- Plan Programs Policies, to determine the amount *we* will pay for services rendered by non- participating health care *providers*. In these situations, *you* may be liable for the difference between the amount that the non- participating health care *provider* bills and the payment *we* will make for the *covered services* as set forth in this paragraph.

☞ **Helpful tip:** In the event that *you* travel outside of Virginia and receive 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 *maximum allowed amount. You* may call Member Services or go to www.anthem.com for information regarding such arrangements.

For coverage overseas

If *you* plan to travel outside the United States, call Member Services and ask for the names of the participating hospitals in the area *you* will be visiting. If *you* need *inpatient* hospital care while *you're* overseas, show your *Anthem* ID card at the admissions office. The participating hospital will bill *Anthem* for covered expenses. *Anthem* will pay the hospital directly. If *you* go to a non-participating hospital or receive *outpatient* care, *you* will usually have to pay the bills and submit the claims for reimbursement. However, if possible *we* will work out direct payment with the *providers.*

How to find a provider in the network

There are four ways *you* can find out if a *provider* or *facility* is in your network:

- Refer to *your health plan's* directory of network *providers* at www.anthem.com, which lists doctors and health care *facilities* that participate in *your health plan's* network, as well as information about the standards of care in area hospitals.
- Call *Anthem's* Member Services to request a list of doctors and health care *facilities* that participate in *your health plan's* network, based on specialty and geographic area.
- Check with your doctor or health care *facility*.
- Ask your *group administrator.*

All network *providers* have a process in place to help *you* access urgent medical care 24 hours a day, 7 days a week. If *you* require urgent medical care after your doctor's normal business hours call his/her office and *you* will be directed to needed care.

Out-of-network care

Out-of-network care is covered at a lower level of benefits than in-network care. After *you* satisfy a calendar year *deductible* (if any), *you* are responsible for your *coinsurance,* a percentage of the *maximum allowed amount* as stated in the Summary of benefits (see page 1). If the *out-of-network* ambulance, *provider* or *facility* participates in any *Anthem* network or other Blue Cross Blue Shield company's network, they will accept the *maximum allowed amount* as payment in full for their services. However, ambulances, *providers* and *facilities* that do not participate in any *Anthem* or Blue Cross Blue Shield company's network may bill *you* for the difference between their charge and the *maximum allowed amount.*

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

The advance approval process

Your health plan will make coverage decisions on services requiring advance approval (for example, *home care services,* etc.), within 15 days from the receipt of the request. *Your health plan* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* 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, *your health plan* will make its decision within 2 working days of its receipt of all necessary clinical 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 *your health plan* 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 *your health plan'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 *your health plan* 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.

Approvals of care involving an ongoing course of treatment

Network *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-network *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 time frame 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.

In an emergency or if specialty care is not reasonably available in the network

If you have an *emergency medical condition,* go to the nearest appropriate *provider* or medical *facility*. If the *provider* or *facility* is not in the network, *you* or your network physician can call *Anthem* to have the *out-of-network* services authorized for the highest level of benefits.

If specialty care is required and it's not available from a *provider* within the network, your network *provider* can call *Anthem* in advance of your receiving care to have the *out-of-network* services authorized for the highest level of benefits.

Hospital Admission Review

All hospital *stays,* skilled nursing home *stays,* or treatment in partial day programs should be approved before each admission. The exception to this is maternity admissions as specified in the maternity section of this booklet. If *you* are admitted to the hospital as a result of an *emergency medical condition,* your hospital *stay* should be reviewed by *Anthem* within 48 hours of admission. The emergency room doctor, a relative, or a friend can call for Hospital Admission Review. Network *providers* and *facilities* handle Hospital Admission Review for *you. You* must initiate the Hospital Admission Review process for *out-of-network* services. If *you* fail to obtain approval for an *inpatient stay,* and the *stay* is later determined by *Anthem* not to be *medically necessary, you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient. Anthem* may not require strict adherence to this procedure for services that arise over the weekend.

Before *you* are admitted to the hospital for medical care or surgery, *you* or someone *you* authorize must call the Member Services telephone number located on your identification card. If your *provider* is calling on your behalf, the telephone number for *providers* is 804-342-0010 in Richmond or toll-free 800-533-1120. *You* should have the following information available:

- your Anthem Blue Cross and Blue Shield identification number (shown on your ID card);
- your doctor's name and phone number;
- the date *you* plan to enter the hospital and length of *stay;* and
- the reason for hospitalization.

Your health plan 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. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* 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 time frame.

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 *your health plan'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 *your health plan* 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 for the treatment of breast cancer 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*.

Admissions to hospitals located outside of Virginia

If *you* are admitted to a hospital outside of Virginia, *you* or someone on your behalf must initiate the Hospital Admission Review process. This applies in all cases, whether *you* live, work, or travel outside of Virginia. If approval is not obtained for an *inpatient stay* and the *stay* is later determined by *Anthem* not to be *medically necessary, you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were *inpatient.*

Individual case management

In addition to the *covered services* listed in this booklet, *your health plan* may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive *covered services.* This includes, but is not limited to, long term *inpatient* care. *Your health plan* will provide alternate benefits at its sole discretion. It will do so only when and for so long as it decides that the services are *medically necessary* and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If *your health plan* elects to provide alternate benefits for a *covered person* in one instance, it will not be required to provide the same or similar benefits for any *covered person* in any other instance. Also, this will not be construed as a waiver of *your health plan's* right to enforce the terms of *your health plan* in the future in strict accordance with its express terms.

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

If you changed plans 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 limitations will apply as of your *effective date* of coverage under the new employer's health plan. Amounts that may have accumulated toward similar limitations under your former employer's health plan will not count toward the limitations under your new employer's health plan.
- If *you* do not change employers, but move from *Anthem* HealthKeepers coverage (issued by an *Anthem* - affiliated HMO) to *Anthem* coverage during the calendar year, new limitations will apply as of the *effective date* of your *Anthem* coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket requirements under the *Anthem* HealthKeepers will not count toward the limitations under the *Anthem* coverage.

- If *you* do not change employers, but move from non-*Anthem* coverage (issued by any other company) to *Anthem* coverage during the calendar year, new limitations will apply as of the *effective date* of your *Anthem* coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket requirements under the non-*Anthem* coverage will not count toward the limitations under the *Anthem* coverage. However, in the course of moving to *Anthem* coverage with your employer, *you* may be eligible for credit of *deductible* and/or out-of-pocket expense limit amounts accumulated under the non-*Anthem* coverage. Please see your *group administrator* for more information.
- If *you* do not change employers, but move from one *Anthem* benefit plan or option to another *Anthem* benefit plan or option during the calendar year, any amounts that had accumulated toward calendar year limitations before the change will count toward similar limitations under the new *Anthem* benefit plan or option for the remainder of the calendar year.

If you have a pre-existing condition

During the first 12-months of coverage, services for *pre-existing conditions* are not covered. This is considered your pre-existing period.

The pre-existing period does not apply to:
- any *covered person* under age 19;
- pregnancy; or
- *covered services* for breast cancer when the *covered person* has been breast cancer free for at least five years.

We will reduce the pre-existing period by the aggregate amount of time, if any, *you* were covered by creditable coverage, which means coverage under any of the following:
- a group health plan;
- individual health insurance coverage;
- health insurance coverage consisting of medical care provided under any insurance policy, HMO contract, or hospital or medical service plan contract offered by a health insurer;
- Medicare, Medicaid, or Tricare;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- the Federal Employees Health Benefits Program
- a public health plan, which means a plan established or maintained by a state, the U.S. government, a foreign country, or a political subdivision of any of these;
- a health benefit plan under the Peace Corps Act; or
- coverage under a State Children's Health Insurance Program authorized by the Social Security Act.

So that *we* may reduce the pre-existing period by the amount of time *you* were covered under creditable coverage, *we* may require *you* to give *us* a copy of any certificates of creditable coverage that *you* have. If *you* do not have a certificate, but *you* have creditable coverage, *we* will help *you* obtain one from your prior plan or issuer. Please contact *us* if *you* need help demonstrating creditable coverage.

If your coverage under this health plan ends, or a covered dependent reaches the maximum age limit, *we* will issue a certificate of creditable coverage. *We* 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:

Anthem Blue Cross and Blue Shield
Attention: Member Services
P.O. Box 27401
Richmond, VA 23279

Telephone:
804-358-1551
in Richmond
800-451-1527
from outside Richmond

If *you* have experienced a *significant break in coverage,* the previous coverage will not reduce the pre-existing period for this coverage.

We will not reduce the pre-existing period for any amount of time *you* were covered by:

- accident or disability income insurance, liability insurance, workers' compensation benefits, automobile medical insurance, credit insurance, or coverage for onsite medical clinics;
- another employer's waiting period;
- limited scope dental benefits, limited scope vision benefits, or long-term care benefits;
- coverage under health flexible spending arrangements that are "excepted benefits" (as defined in federal regulations); or
- health benefits that are secondary or incidental.

What is covered

Anthem covers only those medical services that are *medically necessary*. Just because the service is prescribed by a *provider* does not mean the service is *medically necessary*. In addition, *your health plan* requires that services be safely performed in the least costly *setting*.

See the **Summary of benefits** (page 1) for payment levels and limits for the covered services. For details of the specific coverage provided as well as what is not covered, use the page number references on the summary. All of the following services, except as noted, must be rendered by covered *facilities* or *providers*.

Ambulance travel

Your health plan covers professional ambulance services to or from the nearest *facility* or *provider* adequate to treat your condition. Ambulance services billed through the *facility* are covered the same as all other *facility* services. 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, *we* will take into account whether appropriate, cost-effective care is being provided at the *facility* where the *covered person* is located.

Autism services

Your health plan covers 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.**

Dental services

Your health plan covers:
- *medically necessary* dental services resulting from an accidental injury, provided that, for an injury occurring on or after your *effective date* of coverage, *you* seek treatment within 60 days after the injury. *You* must submit a plan of treatment from your dentist or oral surgeon for prior approval by *Anthem*.
- 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 accidental injury to the jaw, mouth or face;
- dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer; and
- covered general anesthesia and hospitalization services for children under the age of 5, *covered persons* who are severely disabled, and *covered persons* 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 *covered person's* treating physician that such services are required to effectively and safely provide dental care.

Diabetic equipment and education

Your health plan covers 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 purchased from a 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.

Diabetic education may be received from pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Diagnostic tests

Your benefits include coverage for the following procedures when ordered by your doctor 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.

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital *stay* is covered under *your health plan* 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.*

Outpatient diagnostic imaging tools can be the key to identifying underlying health problems, but unnecessary imaging may contribute to patient safety issues: increased radiation exposure and false positive findings that may result in additional unnecessary testing and potential surgical procedures. To help ensure that *you* are receiving services that are safe and appropriate, *we* have made available a health services review process for physicians ordering these services. Health services review is a process performed in advance of receiving an outpatient advanced diagnostic imaging service. The purpose is to review for safety, appropriateness, and medical necessity, and to determine whether the service meets coverage guidelines. If your doctor orders one of the following tests for *you, we* suggest that *you* ask your doctor to initiate a health services review by contacting *Anthem:*
- magnetic resonance angiography (MRA);
- magnetic resonance imaging (MRI);
- magnetic resonance spectroscopy (MRS);
- computed tomographic angiography (CTA);
- positron emission tomography (PET) scans;
- computed tomography (CT) scans;
- single photon emission computed tomography (SPECT) scans; and
- nuclear cardiology.

Helpful tip: While there is no penalty if the health services review is not performed in advance of receiving the service, the advantage of the front- end review is that *you* and your doctor know beforehand whether the service is appropriate, medically necessary, and meets coverage guidelines. If advance approval is not obtained and the service is later determined not to be *medically necessary, you* may have to pay for the service.

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 health plan covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

Doctor visits and services

Your health plan covers:
- *visits* to a doctor's office or your doctor's *visits* to your home;
- *visits* to an urgent care center;
- *visits* to a hospital *outpatient* department or emergency room;

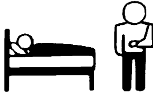
- *visits* for shots needed for treatment (for example, allergy shots); and
- interactive *telemedicine services.*

Early intervention services

Your health plan covers early intervention services for 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 health plan covers emergency room *visits,* services, and supplies. If *you* are admitted to the hospital from the emergency room, the hospital *stays* must be reviewed by *Anthem* within 48 hours of admission. The emergency room doctor, a relative, or a friend can call *Anthem* for Hospital Admission Review (see page 10) in an emergency.

Home care services

Your health plan covers 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 generally confines *you* to your home except for brief absences.

Home private duty nurse's services

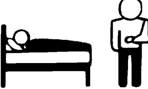
Your health plan covers the cost of medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your doctor must certify to *us* that private duty nursing services are *medically necessary* for your condition, and not merely custodial in nature.

Hospice care services

Hospice care will be covered, for *covered persons* 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 *covered person* in order to provide the *covered person'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);
- *medical equipment (durable);*
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling with respect to the *covered person's* care and death; and
- bereavement counseling for immediate family members both before and after the *covered person's* death.

Hospital services



Your health plan covers 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 20 for an additional discussion of pregnancy benefits.) *Your health plan* covers *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 health plan* covers the *maximum allowed amount* for *medically necessary* services and supplies furnished by the hospital when prescribed by your doctor or *provider*.

The hospital must meet the American Hospital Association's standards for registration as a hospital. Remember that your share of the cost of covered services will change if *you* use a doctor, *facility,* or other health care *provider* that is outside your network.

While *you* are an *inpatient* in the hospital, *your health plan* covers the *medically necessary* services rendered by doctors and other covered *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 health plan 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 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).

Infusion services

Your health plan covers 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.

Maternity

Prenatal and newborn care

If *you* (or your covered dependent) become pregnant, *your health plan* provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered by *your health plan.*

Helpful tip: See **If your family changes** on page 57 for details on when and how to enroll a newborn.

Your benefits include:

- use of the delivery room and care for normal deliveries;
- 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;
- initial examination of a newborn and circumcision of a covered male dependent;
- services for interruption of pregnancy; 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.

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 *copayment you* would have paid if *you* had paid your specialist *copayment* for each prenatal and postnatal *visit, Anthem* or your *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.

Future Moms

You (or your covered dependent) are 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.

Medical equipment (durable)

Your health plan will cover the rental (or purchase if that would be less expensive) of *medical equipment (durable)* when prescribed by your doctor. Also covered are maintenance and necessary repairs of *medical equipment (durable)* except when damage is due to neglect.

Coverage includes the following types of equipment:

- nebulizers;
- hospital type beds;

- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

Medical devices, prosthetics, and appliances

Your health plan covers the cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for *activities of daily living:*
- prosthetic devices and components;
- 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.

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 the prosthetic device.

Medical formulas

Your health plan covers special medical formulas which are the primary source of nutrition for covered persons 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

Medical supplies are covered under *your health plan* if they are prescribed by a covered *provider*. Examples of medical supplies include:
- hypodermic needles and syringes;
- oxygen and equipment (respirators) for its administration;
- prescription medications provided by your doctor; and
- prescription medications infused through IV therapy in the physician's office or *outpatient facilities.*

Certain medical supplies may be covered under the *prescription drug* card feature of *your health plan* when purchased by *you* and supplied directly to *you* by a pharmacy. If so, these supplies will be listed and covered under **Prescription drugs** on page 24.

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. *You* can select any mental health and substance abuse provider listed in *your 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. Coverage for *inpatient mental health services* and substance abuse services is subject to the Hospital Admission Review provisions of *your health plan*. Please see Hospital Admission Review in the **How your health plan works** section for additional information. Please note that *inpatient* services for substance abuse treatment must not be merely custodial, residential, or domiciliary in nature and 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. Obtaining authorization in advance is recommended. 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. Obtaining authorization in advance is recommended.

Medication management

Visits to *your 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.

Prescription drugs and diabetic supplies

Your health plan covers *prescription drugs* if received through a pharmacy, a doctor's office, or a hospital.

Benefits provide for diabetic supplies to treat diabetes. This includes coverage for the following:
- home blood glucose monitors;
- lancets and test strips; and
- hypodermic needles and syringes.

Also covered are *prescription drugs* and devices approved by the Food and Drug Administration (FDA) for use as contraceptives. This includes coverage for office visits associated with contraceptive management.

If *you* receive *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 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. Simply choose a pharmacy that participates in the retail pharmacy network and show your ID card to receive benefits.

To find a pharmacy that participates in the retail pharmacy network *you* should:
- refer to *your health plan's* directory of network *providers* at www.anthem.com, which lists pharmacies that participate in the retail pharmacy network;
- check with your local pharmacy to see if they participate in the retail pharmacy network; or
- call *Anthem's* Member Services.

Pharmacies in the retail pharmacy network, available nationwide, will automatically file claims for *you* and charge *you* only the required *copayment* amount under your health care plan for covered prescriptions.

From time to time *we* may initiate various programs to encourage *covered persons* 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.

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.

Anthem Blue Cross and Blue Shield and its pharmacy benefits manager (PBM) receive financial credits from drug manufacturers based on the total volume of claims processed for their products utilized by *Anthem* 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 the **Summary of benefits** to determine your *deductible* (if any) and *copayment* amounts. *Prescription drugs* will always be dispensed as ordered by your physician. *You* may request, or your physician may order, the brand name drug. However, if 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 *covered persons* to pay a reduced *copayment* 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.

Your health plan 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 below to request a non- formulary drug and *we* will act on your request within 1 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 *Anthem* 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 *Anthem* 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.

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 *Anthem's* Member Services if *you* need a Direct Member Reimbursement Claim Form or if *you* have any questions about your drug program and 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 mail order pharmacy Patient Profile Questionnaire which is enclosed within the mail order

pharmacy envelope. This is needed for your first order only.
3. mail your questionnaire, written prescription(s), and a check to cover the amount of your *copayment(s)* 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.

☞ **Helpful tip:** We suggest that you order your refill two weeks before you need it to avoid running out of your medication.

☞ **Helpful tip:** If you have questions concerning the mail order program you can call Member Services at 800-451-1527.

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 have used 75% of your prescription. Mail the refill notice and the appropriate *copayment* amount to the mail order pharmacy in the envelope provided.

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 1-800-870-6419. *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.

Services of non-participating pharmacies

Notwithstanding any provision in this booklet to the contrary, *you* have coverage for *outpatient* prescription drug services provided to *you* by a non-participating pharmacy that has previously notified *Anthem* of its *agreement* to accept reimbursement for its services at rates applicable to *Anthem* specialty pharmacy network providers 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 pharmacies participating in the specialty pharmacy network. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy *agreement* with *Anthem* or its designee within thirty days of being requested to do so in writing by *Anthem,* 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.

Prior authorization

Your health plan requires 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. This list is periodically modified. *You* may obtain a copy of this list by simply contacting Member Services or from the Internet at www.anthem.com. 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 doctor will be notified of both approval and denial decisions.

Anthem 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.

Routine vision care

To help care for your eyes, *your health plan* includes benefits for one routine eye examination per *covered person* per calendar year. In order to receive the highest level of benefits, *you* should seek care from a Blue View Vision participating *provider*.

For more specific information on what *you* will be responsible for paying, please refer to the **Summary of benefits** section of this booklet.

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 804- 358- 1551 in Richmond or 800- 451- 1527 to order a claim form or visit our website at www.anthem.com for a copy of the claim form.
2. Please include the completed and signed claim form and any 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 any itemized bills for covered services to:
   Blue View Vision, Attn: OON Claims
   P. O. Box 8504
   Mason, OH 45040- 7111

Shots (Injections)

Your health plan covers therapeutic injections (shots) that a *provider* gives to treat illness (e.g., allergy shots) or pregnancy- related conditions. Also included is allergy serum for allergy shots. In addition, you have coverage for immunizations and self- administered injections.

Some injections may be administered by pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Skilled nursing facility stays

Your coverage includes benefits for skilled nursing home *stays*. Coverage for your *stay* requires prior approval. Your doctor must submit a plan of treatment that describes the type of care you need. The following items and services will be provided to *you* as an *inpatient* in a skilled nursing bed of a *skilled nursing facility:*

- 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 health plan 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 other manual medical interventions

Your health plan covers spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations such as massage and myofascial release.

Surgery

General surgery

Surgery charges are covered 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.

Morbid obesity treatment

Your health plan covers treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). Coverage is restricted to surgical procedures and does not include weight control dietary supplements. According to the NIH guidelines, gastric bypass surgery is effective for the long- term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

As used above, body mass index equals weight in kilograms divided by height in meters squared. Coverage does not include weight control dietary supplements or weight loss medications, unless such supplements are recognized by the National Institutes of Health as effective treatment for the long- term reversal of morbid obesity for *covered persons* meeting the requirements specified above.

Reconstructive breast surgery and mastectomy

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 *covered person*.

Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts is also covered.

Oral surgery

Your health plan covers oral surgery for:
- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction;
- 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;
- surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; and
- the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

Organ and tissue transplants, transfusions

Your health plan covers organ and tissue transplants and transfusions. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.

Helpful tip: Certain organ or tissue transplants are considered *experimental/investigative* or not *medically necessary*. You may wish to contact Member Services or have your provider initiate the pre- authorization process to determine if a specific transplant will be covered.

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.

Therapy

Your health plan covers the following therapies when the treatment is *medically necessary* for your condition and provided by a licensed therapist:

Cardiac rehabilitation therapy

Your health plan 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 health plan covers the treatment of disease by chemical or biological antineoplastic agents.

Occupational therapy

Your health plan covers occupational therapy, which 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.

Physical therapy

Your health plan covers physical therapy, which 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.

Radiation therapy

Your health plan covers 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 health plan covers respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Speech therapy

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

Vision correction after surgery or accident

Your health plan covers 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 health plan covers preventive care services for children, adolescents and adults. Preventive care services generally include check-up visits, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance.

Services are covered as preventive care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, but instead benefits will be considered under the diagnostic services benefit.

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and your *provider* performs additional necessary covered services, these services will generally be covered as diagnostic and/or surgical services and not as preventive care services. Also, covered screenings that *you* undergo because *you* have a personal or family history of a particular condition are not generally covered as preventive care services. *Deductibles, copayments* and *coinsurance* amounts applicable to diagnostic and/or surgical services may be different from those applicable to preventive care services. Please see the Diagnostic tests and Surgery sections on the **Summary of benefits** for more information.

The preventive care services in this section meet the requirements outlined under federal and state law. Many preventive care services covered by *your health plan* are not subject to cost shares (for example, *deductible, copayment,* and/or *coinsurance* amounts) when services are received from in-network *providers*. That means *Anthem* pays 100% of the *maximum allowed amount*. These services fall under four broad categories as shown below:

1. services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   - breast cancer;
   - cervical cancer;
   - colorectal cancer;
   - high blood pressure;
   - type 2 diabetes mellitus;
   - cholesterol;
   - child and adult obesity.

2. immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

You may call Member Services at 800- 451- 1527 for additional information about these services. *You* may also visit the federal government websites:

- http://www.healthcare.gov/center/regulations/prevention.html;
- http://www.ahrq.gov/clinic/uspstfix.htm; or
- http://www.cdc.gov/vaccines/recs/acip/.

Your health plan also covers prostate cancer screenings including digital rectal exam and PSA test, as required by state law.

What is not covered (Exclusions)

This list of services and supplies that are excluded from coverage by *your health plan* will not be covered in any case.

A

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

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, and ice bags; or
- benefits for, or related to, **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 do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. Cosmetic surgeries and/or procedures also do not include surgeries or procedures on newborn children to correct congenital abnormalities. *We* 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** services:

- 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 injury and *you* submitted a treatment plan to *Anthem* for prior approval;
- dental care, treatment, supplies, or dental x- rays;
- damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered;
- extraction of either erupted or impacted wisdom teeth;

- oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures;
- appliances for temporomandibular joint pain dysfunction; or
- periodontal care, prosthodontal care or orthodontic care.

This exclusion will not apply if your group's coverage includes a dental rider.

Your coverage does not include benefits for **donor** searches for organ and 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 certificate or when received as part of a covered wellness services *visit* or screening.

Your coverage does not include benefits for **experimental/investigational** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer. The criteria for deciding whether a service is experimental/investigative or a clinical trial cost for cancer is set forth in **Exhibit A.**

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 any drugs administered in connection with these procedures;
- any services or supplies provided to a person not covered under *your health plan* in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- drugs used to treat infertility; or
- services to reverse voluntarily induced sterility.

Your coverage does not include benefits for palliative or cosmetic **foot** care 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.

G

Your coverage does not include services for surgical treatments of **gynecomastia** for cosmetic purposes.

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 this certificate.

Your coverage does not include benefits for the following **home care** services:
- homemaker services;
- 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*.

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 page 34 of this booklet.

M

Your coverage does not include benefits for **medical equipment (durable), appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use. These include:
- 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; 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 if they are deemed not **medically necessary** as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent *you* from appealing Anthem's decision that a service is not *medically necessary*.

However, if *you* receive *inpatient* or *outpatient* services that are denied as not *medically necessary,* or are denied for failure to obtain the required pre- authorization, the following professional provider services that you receive during your *inpatient stay* or as part of your *outpatient* services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:
For *inpatients*

1. services that are rendered by professional providers who do not control whether *you* are treated on an *inpatient* basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than *inpatient* evaluation and management services provided to *you*. *Inpatient* evaluation and management services include routine visits by your attending provider 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 attending provider.

For *outpatients* - services of pathologists, radiologists and anesthesiologists rendering services 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.

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

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

The exception to this exclusion is for morbid obesity as set forth in the "**Surgery**" paragraph of the "**What is covered**" section.

Your coverage does not include benefits for **organ** or tissue transplants, including complications caused by them, except as outlined on page 31 of this book.

P

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

Your ***prescription drug*** benefit does not include coverage for:
- over the counter drugs;
- any per unit, per month quantity over the plan's limit;
- drugs used mainly for cosmetic purposes;
- drugs that are experimental, investigational, or not approved by the FDA (see page 83);
- cost of medicine that exceeds the *maximum allowed amount* for that prescription;
- medications used to treat sexual dysfunction;
- drugs for weight loss;
- stop smoking aids;
- therapeutic devices or appliances;
- injectable *prescription drugs* that are supplied by a *provider* other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed *provider;*

- any refill dispensed after one year from the date of the original prescription order;
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or
- medicine furnished by any other drug or medical service.

Your coverage does not include benefits for **private duty nurses** in the *inpatient* setting.

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.

Your coverage does not include benefits for care from a **residential treatment center** or other non-skilled settings, except to the extent such setting qualifies as a substance abuse treatment facility 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.

S

Your coverage does not include benefits for **services or supplies** if they are:
- ordered by a doctor whose services are not covered under *your health plan;*
- care of any type given along with the services of an attending *provider* whose services are not covered;
- benefits for charges from stand-by physicians in the absence of *covered services* being rendered;
- 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;
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- 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;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not *you* waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;
- 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;

- received from an employer mutual association, trust, or a labor union's dental or medical department;
- for injuries or illnesses incurred as a result of your commission of, or attempt to commit, a crime; or
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

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; or
- biofeedback, neurofeedback, and related diagnostic tests.

Your coverage does not include benefits for surgeries for **sexual dysfunction.** In addition, your coverage does not include benefits for services for **sex transformation.** 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 **spinal manipulations** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

T

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.

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 under age 3 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.

V

Your coverage does not include 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.

Your coverage does not include benefits for the following **vision** services:
- vision services or supplies unless needed due to eye surgery and accidental injury;
- routine vision care and materials, except as outlined on page 28 of this booklet;
- experimental/investigative vision procedures or materials, as well as services related to or complications from such procedures;
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury;
- sunglasses or safety glasses and accompanying frames of any type;
- any non- prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;
- any lost or broken lenses or frames;
- any blended lenses (no line), oversize lenses, 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, or 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 *your health plan*. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to *medically necessary* treatments for morbid obesity.

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. 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.

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. Also, the dates of service will affect your *deductible* (if any) and other minimums described in the **Summary of benefits** and in this section.

Out- of- network calendar year deductible

Your benefits include a calendar year *deductible* for *covered services* that *you* receive *out- of- network.* Before *we* will make payments for *covered services* received *out- of- network, you* must first satisfy the calendar year *deductible.* See the **Summary of benefits** section of this booklet for the amount of your calendar year *deductible.*

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.

Limits on your out- of- pocket expenses

Your health plan protects *you* from large out- of- pocket expenses by limiting the amount *you* spend out of your own pocket each year. Once the limit on *your health plan* is reached, almost all other covered expenses are paid in full for the rest of the calendar year.

What you will pay

In- network limit

Copayments and *coinsurance* for services by *providers* and *facilities* within your network count toward your in- network, out- of- pocket expense limit. When your in- network, out- of- pocket expense limit is reached, *copayments* and *coinsurance* for in- network services will no longer apply for the rest of the calendar year. Two special situations when expenses will also count toward this limit are:

- when *you* receive services from medical suppliers for whom there is no network (e.g., private duty nurses), your out- of- pocket expenses count toward this limit; and
- when specialty care is not available within the network and *Anthem* authorizes the highest level of benefits, any *copayments* and *coinsurance* for these *covered services* count toward this limit.

Out- of- network limit

Deductibles and *coinsurance* for *covered services* by *providers* and *facilities* who are not part of your *KeyCare PPO Network,* but who participate in an *Anthem* or Blue Cross and Blue Shield Company's network, count toward your *out- of- network,* out- of- pocket expense limit. If *you* reach your *out- of- network,* out- of- pocket expense limit, *you* will no longer pay *coinsurance* for *out- of- network* services for the rest of the calendar year.

☞ **Helpful tip:** The in-network and *out-of-network* out-of-pocket expense limits are separate, and amounts applied to one do not apply to the other.

What does not count toward these limits

The following amounts do not count toward your out-of-pocket expense limit, and *you* will always be responsible for these expenses, regardless of whether *you* have met your out-of-pocket expense limit.

- amounts above the *maximum allowed amount;*
- amounts above health plan limits;
- *copayments* for *prescription drugs* under your *prescription drug* card benefit;
- *copayments* and *coinsurance* for routine vision care;
- *deductible* amounts carried forward from the prior calendar year;
- expenses for supplies or services not covered by *your health plan;* or
- *deductible, copayments,* and *coinsurance* for dental services provided by separate contract, certificate, or amendment to this health plan.

How Anthem pays a claim

How *we* pay a claim takes into account the *maximum allowed amount* for the service, the network status of the *provider* or *facility* where *you* receive services, and your member cost share under *your health plan's* benefit design. Each of the components is explain in the section that follows.

Maximum allowed amount

This section describes how *we* determine the amount of reimbursement for *covered services.* Reimbursement for services rendered by in-network and *out-of-network providers* is based on *your health plan's maximum allowed amount* for the *covered service* that *you* received. Please see the BlueCard section for additional information.

The *maximum allowed amount* for *your health plan* is the maximum amount of reimbursement *Anthem* will allow for services and supplies:

- that meet *our* definition of *covered services,* to the extent such services and supplies are covered under *your health plan* 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 plan.

You will be required to pay a portion of the *maximum allowed amount* to the extent *you* have not met your *deductible* or have a *copayment* or *coinsurance.* In addition, when *you* receive *covered services* from non-participating *providers, you* may be responsible for paying any difference between the *maximum allowed amount* and the *provider's* actual charges. This amount can be significant.

When *you* receive *covered services* from a *provider, we* will, to the extent applicable, apply claim 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, the *maximum allowed amount* will be based on the 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 amounts* for those secondary and subsequent procedures because reimbursement at 100% of the *maximum allowed amount* for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Assistant at surgery

Services of a physician who actively assists the operating surgeon to perform a covered surgical service are *covered services.* However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the *maximum allowed amount* will not be more than that available to one surgeon.

Provider network status

The *maximum allowed amount* may vary depending upon whether the *provider* is an in-network *provider* or an *out-of-network provider*.

An in-network *provider* is a *provider* who is in the *KeyCare PPO network,* the managed network for this specific health plan. For *covered services* performed by an in-network *provider* the *maximum allowed amount* for *your health plan* is the rate the *provider* has agreed with *Anthem* to accept as reimbursement for the *covered services.*

Providers who are not in the *KeyCare PPO network,* but contracted for other products with *us* are considered non-network participating *providers.* While your cost share may be higher because these *providers* are not in-network, these non-network participating *providers* have agreed to accept the *maximum allowed amount* established by the *provider's* contract as payment in full for those *covered services.* Choosing an in-network *provider* will likely result in lower out-of-pocket costs to *you.*

Because in-network *providers* and non-network participating *providers* have agreed to accept the *maximum allowed amount* as payment in full for those *covered services,* 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 all or a portion of the *maximum allowed amount* to the extent *you* have not met your *deductible* or have a *copayment* or *coinsurance*. Please call Member Services for help in finding an in- network *provider* or visit www.anthem.com.

Providers who have not signed any contract with *us* and are not in any of *our* networks are *out- of- network providers*. For *covered services you* receive from an *out- of- network provider*, the *maximum allowed amount* for *your health plan* will be one of the following as determined by *Anthem:*

1. an amount based on *our* non- participating *provider* fee schedule/rate, which *we* have established in *our* discretion, and which *we* reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar *providers* contracted with *Anthem*, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data or
2. an amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or
3. an amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable *providers'* fees and costs to deliver care; or
4. an amount negotiatedby *us* or a third party vendor which has been agreed to by the *provider*. This may include rates for services coordinated through case management; or
5. an amount equal to the total charges billed by the *provider*, but only if such charges are less than the *maximum allowed amount* calculated by using one of the methods described above.

Member Services is also available to assist *you* in determining *your health plan's maximum allowed amount* for a particular service from an *out- of- network provider*. In order for *us* to assist *you*, *you* will need to obtain from your *provider* the specific procedure code(s) and diagnosis code(s) for the services the *provider* will render. *You* will also need to know the *provider's* charges to calculate your out- of- pocket responsibility. Although Member Services can assist *you* with this pre- service information, the final *maximum allowed amount* for your claim will be based on the actual claim submitted by the *provider*.

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's benefit 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).*

Your cost share amount and out-of-pocket limits may vary depending on whether *you* received services from an in-network or *out-of-network provider*. Specifically, *you* may be required to pay higher cost sharing amounts or may have limits on your benefits when using *out-of-network providers*. Please see the **Summary of benefits** in this certificate for your cost share responsibilities and limitations, or call Member Services to learn how this plan's benefits or cost share amounts may vary by the type of *provider you* use.

Anthem 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*, regardless of whether such services are performed by an in-network or *out-of-network provider*. 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.

In some instances *you* may only be asked to pay the lower in-network cost sharing amount when *you* use an *out-of-network provider*. For example, if *you* go to an in-network hospital or *provider facility* and receive *covered services* from an *out-of-network provider* such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an in-network hospital or *facility*, *you* will pay the in-network cost share amounts for those *covered services*. However, *you* also may be liable for the difference between the *maximum allowed amount* and the *out-of-network provider's* charge.

In some instances, because of the negotiated arrangement with network *facilities* and *providers,* our *maximum allowed amount* may be higher than the *facility* or *provider* billed charge for the *covered services*. In these cases, any *coinsurance* amount that *your health plan* imposes will be based off the lower billed charges.

☞ **Helpful tip:** The following examples are illustrative only, and are not intended to reflect the actual member cost share amounts reflected on the **Summary of benefits.**

Example: Your plan has a *coinsurance* cost share of 20% for in-network services, and 30% *out-of-network* after the in- or *out-of-network deductible* has been met. *You* undergo a surgical procedure in an in-network hospital. The hospital has contracted with an *out-of-network* anesthesiologist to perform the anesthesiology services for the surgery. *You* have no control over the anesthesiologist used.

- the *out-of-network* anesthesiologist's charge for the service is $1200. The *maximum allowed amount* for the anesthesiology service is $950; your *coinsurance* responsibility is 20% of $950, or $190 and the remaining allowance from *us* is 80% of $950, or $760. *You* may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the *deductible* has been met, your total out of pocket responsibility would be $190 (20% *coinsurance* responsibility) plus an additional $250, for a total of $440.

- *you* choose an in-network surgeon. The charge was $2500. The *maximum allowed amount* for the surgery is $1500; your *coinsurance* responsibility when an in-network surgeon is used is 20% of $1500, or $300. *We* allow 80% of $1500, or $1200. The in-network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.
- *you* choose an *out-of-network* surgeon. The *out-of-network* surgeon's charge for the service is $2500. The *maximum allowed amount* for the surgery service is $1500; your *coinsurance* responsibility for the *out-of-network* surgeon is 30% of $1500, or $450 after the *out-of-network deductible* has been met. *We* allow the remaining 70% of $1500, or $1050. In addition, the *out-of-network* surgeon could bill *you* the difference between $2500 and $1500, so your total out of pocket charge would be $450 plus an additional $1000, for a total of $1450.

Authorized services

In some circumstances, such as where there is no in-network *provider* available for the *covered service, we* may authorize the network cost share amounts (*deductible, copayment,* and/or *coinsurance)* to apply to a claim for a *covered service you* receive from an *out-of-network provider.* In such circumstance, *you* must contact *us* in advance of obtaining the *covered service. We* also may authorize the network cost share amounts to apply to a claim for *covered services* if you receive *emergency services* from an *out-of-network provider* and are not able to contact *us* until after the *covered service* is rendered. If *we* authorize a *covered service* so that *you* are responsible for the in-network cost share amounts, *you* may still be liable for the difference between the *maximum allowed amount* and the *out-of-network provider's* charge. Please contact Member Services for authorized services information or to request authorization.

Example: *You* require the services of a specialty *provider,* but there are no in-network *providers* for that specialty in your state of residence. *You* contact *us* in advance of receiving any *covered services,* and *we* authorize *you* to go to an available *out-of-network provider* for that *covered service* and *we* agree that the in-network cost share will apply.

Your plan has a $45 *copayment* for *out-of-network provider* and a $25 *copayment* for in-network *providers* for the *covered service.* The *out-of-network provider's* charge for this service is $500. The *maximum allowed amount* is $200.

Because *we* have authorized the in-network cost share amount to apply in this situation, *you* will be responsible for the in-network *copayment* of $25 and *Anthem* will be responsible for the remaining $175 of the $200 *maximum allowed amount.*

Because the *out-of-network provider's* charge for this service is $500, *you* may receive a bill from the *out-of-network provider* for the difference between the $500 charge and the *maximum allowed amount* of $200. Combined with your in-network *copayment* of $25, your total out of pocket expense would be $325.

Network and participating providers and facilities

If *you* go to a network or participating *provider* or *facility, we* will pay the *provider* or *facility* directly. If *coinsurance* or a *copayment* is applicable to *covered services* rendered by a network or participating *facility* or *provider,* or if any applicable *deductible* is not met, any such amounts may be collected at the time of service.

Non- participating providers and facilities

If *you* go to a non- participating *provider* or *facility, 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* will not pay a non- participating *provider* more than *we* would have paid a participating *provider* 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- participating *provider.* In all cases, *our* payment relieves *Anthem* of any further liability for the service.

When you must file a claim

Network *providers* file claims on your behalf. *You* may have to file a claim if *you* receive care from a *provider* or *facility* that does not participate in *Anthem's* network.

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 804- 358- 1551 in Richmond or 800- 451- 1527 to order a claim form or get one from your *group administrator.*
2. Please include the completed and signed claim form and any 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).

   In addition, private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending physician's written certification that the services were *medically necessary,* and the hours the nurse worked.
3. Send the completed claim form and any itemized bills for *covered services* to:
   Anthem Blue Cross and Blue Shield
   P. O. Box 27401
   Richmond, VA 23279

Timely Filing of Claims

Written notice of a claim is to be made within 20 days after the occurrence or commencement of any loss covered by the health plan. However, failure to give this notice shall not invalidate or reduce any claim if the notice is given as soon as reasonably possible. Claim forms will be furnished to *you* if needed within 15 days after this written notice.

Written proof of loss must be furnished within 90 days after the date of service. A proof of loss is not complete unless it is properly filed and contains all information that *Anthem* needs to process the claim. Failure to furnish the proof of loss within this time frame will not invalidate or reduce any claim if the proof of loss is given as soon as reasonably possible. However, no claim will be paid if *we* receive the proof of loss more than 15 months after the date of service, except in the absence of legal capacity of the *covered person.* All benefits payable for a claim will be payable within 60 days after receipt of the proof of loss.

When your claim is processed

In processing your claim, *your health plan* 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. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* 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, *we* will make *our* decision within 2 working days of *our* receipt of the medical information needed to process the claim.

Your health plan 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 *us* within either 15 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 *your health plan, 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 *your health plan'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 *your health plan* 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.

Recovery of overpayment

Anthem shall have the right to recover any overpayment of benefits from persons or organizations that *we* have determined to have realized benefits from the overpayment:
- any person 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 *Anthem'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 coordination of benefits (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 *covered person* is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of benefit determination rules set out in the group policy issued to the *policyholder*. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to this health plan's, the other coverage will be primary.
- If a *covered person* 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 *covered person* 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 *covered person* is enrolled as a dependent 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 *covered person* is enrolled as a dependent 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 this health plan provides secondary coverage, *we* first calculate the amount that would have been payable had this health plan been primary. In no event will this health plan's payment as secondary coverage exceed that amount. This health plan coordinates benefits so that the combination of the primary plan's payment and this health plan's payment does not exceed *our maximum allowed amount*. 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 this health plan 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 this health plan would have paid if it had been primary.

Medicare carve-out benefits

Who has Medicare carve-out benefits

The coverage provided under your group health plan consists of Medicare carve-out benefits if *you* are a *covered person* who is:
- A retiree eligible for Medicare; or
- The Medicare-eligible spouse or dependent of a covered retiree.

Certain persons who are entitled to Medicare due to end stage renal disease may also be eligible for Medicare carve-out benefits. See your *group administrator* for more information.

How Medicare carve-out works

The information in this section pertains to Medicare carve-out benefits for covered medical expenses. Please see the next section, **Important information regarding retiree prescription drug benefits**, for information about prescription drug coverage for Medicare-entitled retirees and Medicare-entitled spouses and dependents of covered retirees.

Persons whose coverage consists of Medicare carve-out benefits must enroll for Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). For all covered services, Medicare pays first, and *your health plan* pays a reduced amount. Medicare carve-out benefits equal *your health plan's* normal benefits for covered services, reduced by the amount of Medicare's benefit payments. If a Medicare carve-out *covered person* fails to enroll for Medicare, *your health plan's* benefit payments will be reduced by an estimate of the amount Medicare would have paid had the individual enrolled. For services that are covered under *your health plan* but not covered by Medicare, *your health plan* will pay its normal benefits. Covered services are detailed in the Summary of benefits (see page 1).

To keep health care costs as low as possible, choose participating health care *providers* who accept Medicare's allowance, or "assignment," for covered services. *Providers* who do so agree to accept the Medicare- approved amount as payment in full for services and supplies covered by Medicare Part B. Charges for services rendered by *providers* who do not accept assignment are often higher.

When *you* receive health care services, give your health care *provider* your Medicare information and all the information on *your health plan* I.D. card. Many health care *providers* will file claims with Medicare and *Anthem*. Payment will be made directly to the *provider* unless the claim shows that *you* have already paid for the services.

Important information regarding retiree prescription drug benefits

Persons who are entitled to Medicare Part A or Part B became eligible for Medicare Part D prescription drug benefits on January 1, 2006, due to the enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003. This section explains the effect of Medicare Part D on your employer- provided prescription drug coverage.

If *you* are entitled to Medicare Part A or Part B, *you* may enroll in Part D as well. See "Coordination of benefits" in the **When you are covered by more than one health plan** section for more information about how your group health plan coordinates with Medicare Part D.

When you must file a claim to Anthem

Many health care *providers* will file claims to both Medicare and *Anthem*. If a health care *provider* or pharmacy will not do so, then *you* will have to file a claim to *Anthem*. Since Medicare pays first, *you* should wait until *you* receive your "Medicare Summary Notice" before filing a claim with *Anthem*. Then follow these steps:

1. Complete and sign an *Anthem* claim form.
2. Attach a copy of the itemized bill from your health care *provider* or pharmacy. *You* can include more than one bill.
3. Attach a copy of the "Medicare Summary Notice" that shows what Medicare paid.
4. Send your claim form, itemized statement and "Medicare Summary Notice" to *Anthem*. Payment will be made directly to *you*.

For more information, including what is needed for itemized bills and how to obtain claim forms from *Anthem,* see **When you must file a claim** on page 49.

Changing your coverage

Who is eligible for coverage

You

You are eligible for coverage after *you* satisfy your employer's eligibility requirements. Eligibility requirements are available from your *group administrator*. Your employer will inform *you* of your *effective date* in accordance with these eligibility requirements.

Your eligible dependents

Eligible dependents include:

- Your spouse or your domestic partner in accordance with your employer's eligibility requirements;
- Your or your domestic partner's children age 26 or younger which includes:
  - a newborn, natural child, or a child placed with *you* or your domestic partner for adoption;
  - a stepchild; or
  - any other child for whom *you* or your domestic partner have 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 a child is age 26. Coverage for children will end on the last day of the month 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 *you* provide proof of handicap and dependence at the time of enrollment.

You may be asked to provide a physician's certification of the dependent's condition.

If *you* and your dependents remain eligible for coverage after *you* retire under your employer's eligibility rules, please see pages 53 and 59 for information about retiree benefits.

Types of coverage

Your employer provides the following enrollment options. After reviewing the available options, *you* may choose the option that best meets your needs. The options are as follows:

- Employee only
- Employee and spouse or domestic partner

- Employee and one child
- Employee and family

When you may enroll

You may enroll:

- **During the initial enrollment period**
  If your employer has purchased a new group policy from *Anthem* and *you* were enrolled under a previous group policy of that employer on the date before this group policy is effective, your *effective date* will be the date the health plan begins. Your *group administrator* can tell *you* what this date is.
- **Within 31 days after becoming eligible**
  Your *effective date* will be the first of the month after the date *you* become eligible.
- **During annual open enrollment periods**
  Your employer will tell *you* the *effective date* if *you* enroll during your company's annual open enrollment period.
- **During a special enrollment period**
  You may have chosen to decline coverage for yourself and/or dependents under this health plan when *you* could have enrolled for it because of coverage under another health plan.

  If *you* declined coverage under this health plan in writing for yourself and/or your eligible dependents and later *you* or your dependent(s) loses the other coverage, *you* 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 your spouse;
    - a reduction in the number of hours of employment;
    - termination of employment for yourself or your 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 your marriage, the birth of a child, or the placement of a child with you for adoption. Within 31 days after the change occurs, you will need to complete an application to add dependents or a change form to delete dependents. In all cases, contact your *group administrator* immediately.

Marriage

The *effective date* of coverage for those added as a result of marriage will be determined by your employer in accordance with its eligibility requirements.

Newborn children

"Newborn child" means:
- a child who is born to *you;* or
- a child who is adopted by *you* or placed with *you* for adoption within 31 days after his or her birth.

A newborn child is covered from the moment of birth if, before the newborn child's birth, adoption or placement:
- *you* already have your dependents covered and adding the newborn child to your coverage would not result in an increase in your premium. *You* should submit an application within 31 days to notify us of your new dependent.
- *you* already have at least one dependent covered, but adding the newborn child would result in an increase in your premium. *You* must submit an application to add the newborn child to your coverage within 31 days and *you* must pay the appropriate premium. If *you* do not do this, the child's coverage will end after 31 days.

If *you* have employee- only coverage before the birth, adoption, or placement of the newborn child, *you* must enroll the child within 31 days. If *you* do, the child will be covered from his or her date of birth. If *you* do not enroll the newborn child within 31 days, you will not be able to add him or her until your next annual open enrollment period.

Other Adopted Children

Other than a newborn child (as defined above), a child who is adopted by *you* or placed with you for adoption is covered from the date of adoption or placement if:
- before the adoption or placement, *you* already have your dependents covered and adding the child would not result in an increase in your premium. *You* should submit an application within 31 days to notify us of your new dependent.
- adding the child would result in an increase in your premium. *You* must submit an application to add the child to your coverage within 31 days after the adoption or placement for adoption. If *you* do not do this, the child's coverage will end after 31 days, and *you* will not be able to add him or her until your next annual open enrollment period.

When a dependent is no longer eligible for coverage, *you* can change your type of coverage by completing a change form to drop the dependent. *We* will change your coverage the first day of the month after *you* submit a change form.

After coverage ends

When a *covered person* ceases to be eligible or the required premiums are not paid, the *covered person's* coverage will end. Unless otherwise agreed to in writing by *Anthem,* the *covered person's* coverage ends on the last day of the month for which payment is made. The *covered person's* coverage ends on the last day of the month during which eligibility ceases.

Examples of when a *covered person's* eligibility may cease include:
- when *you* leave your job with the employer.
- when a child reaches the end of the month in which the child turns 26.
- in the case of a handicapped dependent, when the child is no longer handicapped.
- when an enrolled child over age 26 marries.
- in the case of your spouse, when *you* and your spouse divorce.
- in the case of your domestic partner, when your domestic partner relationship no longer meets your employer's eligibility requirements.

After you become eligible for Medicare

If *you* continue to work after becoming eligible for Medicare due to age (usually at age 65), your Medicare entitlement will not end your eligibility for coverage under this health plan. If *you* are retired and eligible for retiree benefits, please refer to page 53 for information about retiree benefits. See your *group administrator* for more information.

To enroll for Medicare when *you* or a family member becomes eligible for it, *you* must contact the nearest Social Security Office.

When the employee dies

Coverage continues until the last day of the month in which the employee's death occurs unless your family member(s) are eligible for and elect continuous coverage. (See **Continuation of coverage (COBRA)** below.) Your family members are also eligible for an individual policy through *Anthem.*

Continuing coverage when eligibility ends

You and your covered dependents may be eligible for the following:
- continuous group coverage under the COBRA law (Consolidated Omnibus Budget Reconciliation Act);
- continuous group coverage under state law; or
- individual coverage through *Anthem.*

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 covered family members and what *you* need to do to protect your family's COBRA rights.

COBRA continuation is a temporary extension of coverage under *your health plan. You* and your covered family members may be *qualified beneficiaries*. A *qualified beneficiary* is eligible for continued coverage if coverage under *your health plan* 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 under *your health plan* 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 *Anthem* 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 a covered 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 covered 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 covered 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.

Switching to individual coverage

To prevent a lapse in coverage, contact *Anthem* 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 *you* meet enrollment requirements for an individual plan and apply within the time limit, there will be no lapse in coverage. Otherwise, claims may not be paid for a period of time. To make sure *you* know what will be covered, read the individual *Anthem* offer carefully. It will outline:

- enrollment rules;
- the time permitted to accept the offer;
- the waiting period, if any; and
- the benefits and rates of the individual plan.

Twelve- month continuation under state law

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 under state law. 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 plan

Statement of ERISA rights

As a participant in this plan *you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

You may examine, without charge, at your *plan administrator's* office and at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the 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 your *plan administrator*. The administrator may make a reasonable charge for the copies.

Helpful tip: ERISA generally does not apply to church plans or to governmental 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 *plan 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

Your 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 your employer. *We* will notify your employer at least 15 days prior to terminating the group policy for non- payment of a monthly premium. *Anthem* 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 the health plan

We may amend this health plan by giving your employer at least 30 days written notice. Any amendment to the health plan will change *covered services* to *covered persons* on the *effective date* of the change. This applies even though *you* may have an ongoing condition at the time of the change. *We* may not amend this plan to reduce benefits other than on the renewal date of the group policy unless your employer agrees to the change. Your employer and *Anthem* may mutually agree to amend or reduce benefits at any time.

Complaint and appeal process

In order for *your health plan* to remain responsive to your needs, *we've* established both a complaint process and an appeal process. Should *you* have a problem or question about *your health plan,* 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 *us*. Complaints typically involve issues such as dissatisfaction about *your health plan's* services, quality of care, the choice of and accessibility

to *your health plan's providers* and network adequacy. Appeals typically involve a request to reverse a previous decision made by *your health plan*. 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 *your health plan's* receipt of your complaint. If *we* are 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. *We* will then respond to *you* within an additional 30 calendar days.

Important: Written complaints or any questions concerning your health insurance may be filed to the following address:

Anthem Blue Cross and Blue Shield
Attention: Member Services
P.O. Box 27401
Richmond, VA 23279

Appeal Process

Your health plan 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 *your health plan* 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 *your health plan* 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.

Important: *You* may contact Member Services with your appeal or any questions concerning your health insurance at the following:

Address:
Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Telephone:
804- 358- 1551
in Richmond
800- 451- 1527
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 your health plan will handle your appeal

In reviewing your appeal, *we* 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 rescissions, *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 the 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 *Anthem, 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.

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 *your health plan, 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

(Note: This number is separate from the Bureau's existing toll-free number and is exclusive to The Office of the Managed Care Ombudsman)

E-Mail:
ombudsman@scc.virginia.gov

Web Page:
Information regarding The Office of the Managed Care 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 a complaint and/or an appeal concerning the health care services that *you* have been provided which have not been satisfactorily addressed by *us, 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:
804-367-2149

E-Mail:
MCHIP@vdh.virginia.gov

Laws governing this health plan

This health plan is entered into in, and 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.

Notice in writing

If *we* change the health plan, *we* will send *you* written notice. Any notice required under this health plan must be in writing. Notice given to your employer will be sent to your employer's address, stated in the group application as provided by the group. Notice given to a *covered person* will be sent, at *our* option, to your employer or to your address as it appears on *our* records. Your employer or a *covered person* may indicate a new address for giving notice.

Cancellation or termination

Your employer may cancel this health plan on the last day of any month by giving *us* at least 30 days written notice.

We can terminate this health plan when your employer:
- does not pay the appropriate premium when due;
- fails to perform any duties required by the health plan;
- commits fraud or misrepresentation with respect to the health plan. Additionally, a *covered person's* coverage under the health plan may be terminated for fraud or misrepresentation by the *covered person* with regard to his or her coverage;
- fails to comply with *our* underwriting guidelines regarding employer contribution and participation requirements; or
- has no more employees living, residing, or working in *our* service area.

If *we* have issued this policy to an association offering coverage to its membership, *we* may terminate coverage for any subgroup in the association for any of the above occurrences attributable to that subgroup.

We can terminate this health plan when *we* decide, in accordance with state law, to:
- discontinue offering the particular type of group health coverage specified in the health plan. *We* will give at least 90 days written notice to your employer and all *covered persons*.
- discontinue offering all group health insurance coverage in this state. *We* will give at least 180 days written notice to the Virginia State Corporation Commission, your employer, and all *covered persons*.

If your employer is an association offering coverage under the health plan to its membership, *we* will give notice to each association subgroup.

Termination of the health plan automatically ends your coverage. When the health plan is terminated because of an action by your employer, your employer must notify all *covered persons* of the termination of the coverage. However, coverage will end whether or not the notice is given.

Validity of coverage

Your coverage will not be contested after it has been in effect two years, unless premiums have not been paid. Any statement *you* make that *we* may use to contest the validity of your coverage must be written and signed by *you*.

Time limits on legal action

No legal action may be brought against *Anthem* within the 60- day period after proof of loss notice is filed or more than three years after the end of the 90- day period that proof of loss was required to be filed (see page 50). This limit applies to matters relating to this health plan, to *our* performance under this health plan, or to any statement made by an employee, officer, or director of *Anthem* concerning this health plan or the benefits available to a *covered person*.

Limitations of damages

In the event a *covered person* or his representative sues *Anthem,* 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 health plan, the damages shall be limited to the amount of the *covered person'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. Under no circumstances shall this provision be construed to limit or preclude any extra contractual damages that may be available to you or your representative.

Anthem's continuing rights

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

Anthem's relationship to providers

The choice of a health care *provider* is solely the *covered person's. Providers* are neither *Anthem* employees nor agents. *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* in any network is not an indication of the *provider's* or *facility's* quality or skill. *We* make no guarantees about the health of any *providers. We* do not furnish *covered services* but only make payment for them when received by *covered persons.*

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

Assignment of payment

A *covered person* may not assign the right to receive payment for *covered services.* Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict, *Anthem's* right to direct future payments to a *covered person* or any other entity. This provision does not apply to dentists and oral surgeons.

Once *covered services* are rendered by a *provider, Anthem* will not honor requests not to pay the claims submitted by the *provider. Anthem* will have no liability to any person because it rejects the request.

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 Policy and this Member Certificate document, and not by this Member Rights and Responsibilities statement.

Definitions

Activities of daily living
means 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 health plan.

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 you pay for some covered services.

Copayment
is the fixed dollar amount you pay for some covered services.

Cost Awareness
covered persons are individuals designated by the employer (in accordance with the guidelines set by Anthem) who do not have reasonable access to KeyCare PPO Network providers and facilities due to their location.

Covered persons
are you and enrolled eligible dependents.

Covered services
are those medically necessary hospital and medical services which are described as covered in this certificate 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 your health plan will pay for any remaining covered services during that calendar year.

Effective date
is the date coverage begins for you and/or your dependents enrolled under the health plan.

Emergency medical condition (Emergency)
is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency services (Emergency care)
with respect to an emergency medical condition:
- a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
- within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Facilities are:
- dialysis centers
- home health care agencies
- hospice providers
- hospitals
- skilled nursing facilities

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.

Future Moms
is a program designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery.

Group administrator
is the benefits administrator at your employer.

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

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 infusion services rendered in the home setting. Infusion services include such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Infusion services rendered in the home setting do not require that the patient is confined to his/her home.

Inpatient
means when you are a bed patient in the hospital.

Inpatient facilities
are settings where patients can spend the night, including hospitals, skilled nursing facilities, partial day programs.

KeyCare PPO Network
is a network of providers and facilities that has agreed to accept Anthem's maximum allowed amount as payment in full for their services (see page 44 for a definition of maximum allowed amount). When you receive care from KeyCare PPO Network providers and facilities, you won't be charged for any outstanding balances beyond your deductible (if any), copayment, and/or coinsurance amount for covered services detailed in the Summary of benefits (see page 1) .

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
means the amount on which deductible (if any), copayment, and coinsurance amounts for eligible services are calculated.

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.

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

Out- of- network
is care covered at a lower level of benefits. After you satisfy a calendar year deductible, you are responsible for your coinsurance.

Outpatient
is when you receive 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
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.

Policyholder
is the entity who has contracted with Anthem to provide these benefits. This is typically your employer.

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.

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

Pre- service claims
are claims for a service where the terms of the health plan 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.

Primary care physician (PCP)
is the general or family practitioner, internist or pediatrician you choose to provide, arrange and/or authorize any health care services you and your family members may need.

Providers are:
- acupuncturists
- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric mental health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- retail health clinics
- occupational therapists
- opticians
- optometrists
- podiatrists
- registered physical therapists
- speech pathologists

Qualified beneficiary
is a covered person who is eligible for a temporary extension of coverage under your health*plan* because of the COBRA law.

Qualifying event
is an event that allows you or covered persons enrolled with you to select continuation of coverage under the COBRA law.

Referral
is the authorization from your PCP to receive services from another provider.

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.

Setting
is the place where you receive treatment. It could be your home, your provider's office, a hospital outpatient department, a skilled nursing home, hospital inpatient room, or a partial day program.

Significant break in coverage
means a period of 63 consecutive days during which *you* do not have any creditable coverage. Days in a waiting period imposed by your employer do not count toward the 63 days. If you sought individual insurance coverage, the days between when you submitted your completed application and when the individual policy was effective or denied do not count toward the 63 days.

Skilled nursing facility
is a facility licensed by the state in which it operates to provide medically skilled services to inpatients.

Specialty care providers
are any covered providers other than those defined as primary care physicians.

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, less than 90 days apart are considered the same stay, and a new inpatient copayment will not apply.

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 conversation, 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, or multi- source brand 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 your health plan, services for an emergency medical condition do not require PCP referrals or any type of advance approval.

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

We, us, our, Anthem
is Anthem Blue Cross and Blue Shield.

You
the enrolled employee.

Your health plan
Anthem KeyCare plan.

Exhibit A

Experimental/investigative criteria

Experimental/investigative means any service or supply that is judged to be experimental or investigative at *Anthem's* sole discretion. 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, except those drugs used in the treatment of cancer pain and prescribed in compliance with established statutes pertaining to patients with intractable cancer pain, 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 Drug & 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 *covered person* and the physician or health care *provider* who provides the services to the *covered person* conclude that the *covered person'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 *covered person* 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	35
Ambulance	15
Appeals	66
Appliances or medical equipment (durable)	22
Assistant at surgery	45
Babies (or newborn)	20
Benefits summary	1
Birth control (or family planning)	24, 36
Brand name drugs (or prescription drugs)	25
Canceling coverage (or after coverage ends)	59
Changing coverage	55
Chemotherapy	32
Children (or dependents)	55
Chiropractic care (or spinal manipulation or manual medical interventions)	30
Claim filing	49
Clinical trials	36
COBRA	60
Coinsurance	1, 43
Continuing coverage when eligibility ends	59
Coordination of benefits	52
Cosmetic surgery	35
Deductible	1
Dental (oral surgery or periodontal surgery)	16, 35
Dependents	55
Diagnostic tests	16
Dialysis	17
Doctor visits (or office visits)	17
Drugs	24, 39
Eligibility for coverage	55

	page
Emergency care	10
Equipment or medical equipment (durable)	21, 37
Exclusions	35
Experimental services	83
Family planning (or birth control)	36
Fetal screenings	21
Filing a claim	49
Foot care	36
Generic drugs (or prescription drugs)	25
Grievances (or appeals)	66
Hearing	37
Home care services	18, 37
Hospice care	19
Hospital Admission Review	10
Hospital service	19, 37
Immunizations	33
In- network	6
Infertility	39
Infusion	20
Inpatient	19
Investigative	83
Lab (or diagnostic testing)	16
Legal action	72
Manual medical interventions (or spinal manipulation or chiropractic care)	41
Maternity	20
Maximum allowed amount	44
Medical equipment (durable)	21, 37
Mental health	23, 38
Morbid obesity	39

page

Network (or in- network and out- of- network). . 6
Newborn 20
Nursing care (or home health or private duty nursing) 19
Nursing facility (or skilled nursing facility) . 29, 41
Nutrition counseling. 39
Obesity. 39
Occupational therapy 32, 41
Office visits. 17
Oral surgery (or dental or periodontal surgery). 31
Out- of- network. 8
Out- of- pocket 43
Periodontal (or oral surgery or dental) 36
Phone numbers . . . . inside front cover
Physical therapy 32, 41
Pre- existing condition 13
Pregnancy. 20
Premiums. 65
Prescription drugs 24, 39
Preventive care 33
Privacy 74
Private duty nursing 19
Private room (or hospital services) 20

page

Professional providers. 5
Psychiatric/psychological care. 23, 38
Radiation therapy 32
Respiratory therapy 32
Rights and responsibilities 64, 74
Shots 29
Skilled nursing facility 29, 41
Speech therapy. 32, 41
Spinal manipulations 30, 41
Spouses (or dependents). 55
Substance abuse (or mental health) 23, 38
Summary of benefits. 1
Supplies or medical equipment (durable) 22
Surgery. 30
Termination of coverage (or cancellation of coverage) 59
Therapy 32, 41
Transplants. 31, 39
Vision care 33, 42
Weight loss. 39
Well baby. 33
Wellness services 33
X- ray (or diagnostic testing). 16

End of Certificate

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.

Anthem 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

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.

24/7 NurseLine

Illness or injury can happen, no matter what time of day. As an *Anthem* health plan 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 800-337-4770.

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.

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 specializes 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 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'll 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.

Anthem Blue Cross and Blue Shield
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