Anthem HealthKeepers
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Evidence of Coverage

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Take Control of Your Health

Your Health Care Plan

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HealthKeepers, Inc.
Anthem HealthKeepers – Evidence of Coverage

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

Important: This is not an insured benefit plan. The benefits described in this evidence of coverage or any amendments hereto are funded by the employer who is responsible for their payment. HealthKeepers, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Important phone numbers

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

How to obtain language assistance

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

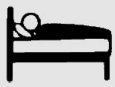
Hours of operation:
Monday-Friday
8:00 a.m to 6:00 p.m.
Saturday
9:00 a.m. to 1:00 p.m.

24/7 NurseLine (Medical Questions and Future Moms)
800-337-4770

Keywords

There are a few key words *you* will see repeated throughout this *EOC*. We've highlighted them here to eliminate confusion and to make the *EOC* easier to understand. In addition, *we* have included a **Definitions** section on page 77 that lists various words referenced. A defined word will be italicized each time it is used.

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



Inpatient

Outpatient

HealthKeepers, we, us, our
Refers to HealthKeepers, Inc.

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

Member
Any subscriber or enrolled dependent.

You, your
Any member.

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

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

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Summary of benefits

In this section, *you* will find an outline of the benefits included in *your* plan and a summary of any *deductibles, coinsurance,* and *copayments* that *you* must pay. Also listed are any calendar year limits that apply. Please read the **What is covered** and prescription drug sections beginning on page 20 for more details on the plan's *covered services.* Read the **What is not covered** section beginning on page 41 for details on excluded services. All *covered services* are subject to the conditions, exclusions, limitations and terms of this *EOC.*

To get the highest benefits at the lowest out-of-pocket costs, you must get covered services from an in-plan *provider*. Benefits for *covered services* are based on the *maximum allowed amount*, which is the most the plan will allow for a *covered service*. When *you* use, an out-of-plan *provider you* may have to pay the difference between the out-of-plan provider's billed charge and the *maximum allowed amount* in addition to any *coinsurance*, *copayments*, *deductibles*, and non-covered charges. This amount can be substantial. Please see the **Claims and payments** section for more details. *Deductibles*, *coinsurance* and calendar year maximums are calculated based upon the *maximum allowed amount*, not the provider's billed charges.

What will I pay?

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

If *you*, the subscriber, are the only person covered by this plan, only the "per member" amounts apply to *you*. If *you* also cover dependents (other family members) under this plan, only the "per family" amounts apply, and the "per member" amount will not apply. The "per family amount may be met in its entirety by one family member, or by a combination of family members.

The out-of-pocket limit generally includes all *deductibles*, copayments (if any) and *coinsurance you* pay during a calendar year. It does not include charges over the *maximum allowed amount* or amounts *you* pay for non-covered services. Please see the Claims and payments section for additional details.

Note: When during the course of one visit, multiple types of service are received where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

	In-plan		Out-of-plan		Detail Page number
	 Per member	 Per family	 Per member	 Per family	
Calendar year deductible	$500	$1000	$750	$1500	51
The most you will pay per calendar year	$4500	$9000	$4500	$9000	

	In-plan		Out-of-plan		Detail
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance** (after calendar year deductible)	**Page number**
Ambulance travel (air and water) Out-of-plan providers may also bill	$150	0%	$0	30%	

	In-plan		Out-of-plan		Detail
	Copayment	Coinsurance	Copayment	Coinsurance (after calendar year deductible)	Page number
you for any charges that exceed the plan's maximum allowed amount. **Important Note:** Air ambulance services for non-emergency hospital to hospital transfers must be approved through precertification. Please see the **What is covered** section for details.					
Ambulance travel (ground) Out-of-plan providers may also bill you for any charges that exceed the plan's maximum allowed amount. **Important Note:** All scheduled ground ambulance services for non-emergency transfers, except transfers from one acute facility to another, must be approved through precertification. Please see the **What is covered** section for details.	$150	0%	$0	30%	
Autism services					21
Applied behavior analysis	$0	20%	$0	30%	
All other services for autism	Copayment/coinsurance determined by service rendered				
Clinical trial costs	Copayment/coinsurance determined by service rendered				21
Diabetic supplies, equipment, and education	Copayment/coinsurance determined by service rendered				22
Diagnostic tests For specific conditions or diseases at an emergency room or outpatient facility department. Copayment is waived if services are billed as part of an emergency room visit.					22
Diagnostic x-rays	$35	0%	$0	30%	
Advanced diagnostic imaging services Includes MRI, MRA, MRS, CTA, PET scans, and CT scans	$0	20%	$0	30%	
Dialysis treatments	$0	20%	$0	30%	27
Doctor visits and/or diagnostic tests in the office setting					23
On an outpatient basis					
Primary Care Physician	$20	0%	$0	30%	
Specialty Care Providers	$40	0%	$0	30%	
Advanced diagnostic imaging services Includes MRI, MRA, MRS, CTA, PET scans, and CT scans	$0	20%	$0	30%	
Early intervention services Covered up to age 3	Copayment/coinsurance determined by service rendered				23
Emergency room visits Copayment waived if admitted **Important Note:** Out-of-plan providers may also bill you for any charges over the maximum allowed amount.	$200	0%	Covered at in-plan benefit level		23
Home care services 100 – visit calendar year limit	$0	20%	$0	30%	24
Hospice care services	$0	0%	$0	30%	25
Hospital services					25
Inpatient admission					

	In-plan		Out-of-plan		Detail
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance** (after calendar year deductible)	**Page number**
Facility services					
Per day	$200	0%	$0	30%	
Per admission maximum	$1000	0%	$0	30%	
Professional provider services	$0	0%	$0	30%	
Infusion services-outpatient services					26
Facility services	$35	0%	$0	30%	
Professional provider services	$35	0%	$0	30%	
Ambulatory infusion centers	$35	0%	$0	30%	
Home services Home care services visit limit does not apply	$0	20%	$0	30%	
Lymphedema	Copayment/coinsurance determined by service rendered				26
Maternity					26
Inpatient admission					
Facility services					
Per day	$200	0%	$0	30%	
Per admission maximum	$1000	0%	$0	30%	
Professional provider services	$0	0%	$0	30%	
Prenatal, postnatal and delivery See the Claims and payments section of the EOC for additional information on copayments for prenatal and postnatal care	$150	0%	$0	30%	26
Diagnostic tests Maternity related, such as ultrasounds and fetal monitor procedures					26
Facility services	$35	0%	$0	30%	
Professional provider services	$35	0%	$0	30%	
Medical equipment (durable), devices, appliances, formulas, supplies and medications					
Medical equipment (durable), devices and appliances	$0	20%	$0	30%	27
Medical formulas, supplies and medications	$0	20%	$0	30%	27
Injectable medications Excludes allergy injections/serum	$0	20%	$0	30%	28
Prosthetics	$0	20%	$0	30%	28
	calendar year deductible does not apply				
Mental health and substance use disorder					28
Inpatient admission (includes residential treatment centers)					
Facility services					
Per day	$200	0%	$0	30%	
Per admission maximum	$1000	0%	$0	30%	
Professional provider services	$0	0%	$0	30%	

	In-plan		Out-of-plan		Detail
	Copayment	Coinsurance	Copayment	Coinsurance (after calendar year deductible)	Page number
Partial day program	$0	0%	$0	30%	
Outpatient treatment					
Medication management, individual therapy sessions up to 30 minutes in duration, and group therapy sessions	$20	0%	$0	30%	
All other outpatient mental health and substance use disorder visits	$30	0%	$0	30%	
Nutritional counseling For eating disorders	Copayment/coinsurance determined by service rendered				
Preventive care for children and adults	$0	0%	$0	30%	
The calendar year deductible (if any) does not apply to preventive care received in plan; however, if preventive care is received from out-of-plan providers, the services will be subject to the calendar year deductible. Screenings received for diagnostic purposes (as billed by the in or out-of-plan provider or facility) are not considered to be preventive care, and therefore will also be subject to the calendar year deductible.					
Skilled nursing facility stays* 100-day per stay limit	$0 after calendar year deductible	20%	$0	30%	31
Spinal manipulation and manual medical therapy services * 30-visits calendar year limit per member. To receive the highest level of benefits, services must be received by a provider that participates in the American Specialty Health Group (ASHG).	$25	0%	$0	30%	31
Surgery					32
Inpatient admission					
Facility services					
Per day	$200	0%	$0	30%	
Per admission maximum	$1000	0%	$0	30%	
Professional provider services	$0	0%	$0	30%	
Outpatient treatment					
Facility services	$150	0%	$0	30%	
Doctor's office					32
Primary Care Physician	$20	0%	$0	30%	
Specialty Care Providers	$40	0%	$0	30%	
Therapy – outpatient services					
Chemotherapy, radiation, cardiac rehabilitation and respiratory					33
Facility services	$35	0%	$0	30%	
Professional provider services	$35	0%	$0	30%	
Physical, speech, and occupational * 30 combined visits per member per calendar year for physical and occupational therapy; 30 visits per member per calendar year for speech therapy.					33

	In-plan		Out-of-plan		Detail
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance** (after calendar year deductible)	**Page number**
Limit does not apply to autism services.					
Facility services	$25	0%	$0	30%	
Professional provider services	$25	0%	$0	30%	

* Services received in-plan and out-of-plan accumulate toward this maximum/limit.

	Detail Page number
Prescription drug retail pharmacy and home delivery (mail order) benefits	34

Each *prescription drug* will be subject to a cost share (e.g., *copayment / coinsurance*) as described below. If *your* prescription order includes more than one *prescription drug*, a separate cost share will apply to each covered *drug*.

Pharmacy out-of-pocket expense limit

(calendar/plan) year limit on out-of-pocket expenses for prescription drugs

Per member	$2,000
Per family	$4,000

Day/supply limitations

Prescription drugs will be subject to various day supply and quantity limits. Certain *prescription drugs* may have a lower day-supply limit than the amount shown below due to other plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

Retail pharmacy (in-network and out of network)	30 days
Home delivery (mail order) pharmacy	90 days
Retail maintenance pharmacy	90 days
Specialty pharmacy (in-network and out-of-network)	90 days* *See additional information in the "Specialty drug copayments /coinsurance" later in this section.

Retail and specialty pharmacy copayments / coinsurance

	Copayment	Coinsurance
Tier 1 prescription drugs	$15	0%
Tier 2 prescription drugs	$30	0%
Tier 3 prescription drugs	$50	0%

Home delivery pharmacy copayments / coinsurance

	Copayment	Coinsurance
Tier 1 prescription drugs	$30	0%
Tier 2 prescription drugs	$60	0%
Tier 3 prescription drugs	$100	0%

Specialty drug copayments / coinsurance

Please note that certain *specialty drugs* are only available from the specialty *pharmacy* and *you* will not be able to get them at a retail *pharmacy* or through the home delivery (mail order) *pharmacy*. Please see "Specialty pharmacy" in the section "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" for further details. When *you* get *specialty drugs* from the specialty *pharmacy*, *you* will have to pay the same *copayments / coinsurance you* pay for a 90-day supply at a retail *pharmacy*.

If *you* do not use the *specialty pharmacy*, benefits will be covered at the out-of-network level

How your coverage works

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

Your coverage is a self-funded employee welfare benefit plan sponsored by your employer. The cost of your coverage, which includes the plan benefits and administrative expenses, is borne by your employer. Employees may contribute to the cost through payroll deduction. Your employer has entered into an administrative services contract with HealthKeepers, Inc. to carry out certain functions with respect to claims operation.

Carry your identification ("ID") card

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

Primary Care Physicians ("PCP")

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

Selecting or changing your Primary Care Physician

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

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

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

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

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

The referral process

Generally, in order to receive benefits, *you* need to seek care from *your PCP* or have a *referral* from *your PCP* to see another provider. *Your PCP* will manage *your* care by determining what specific treatment is necessary.

To obtain a referral

Your PCP must arrange for a *referral* to a *HealthKeepers provider* prior to *your* receiving services. *Your PCP* and *HealthKeepers* will work together to authorize all necessary consultations and *referrals* to other *HealthKeepers providers* or, if no *HealthKeepers provider* is available, non-*HealthKeepers providers.* Specialist services may take place at *your PCP's* office, at another physician's office, or at a hospital. If *you visit* a physician or other health care provider without a *referral, you* will assume responsibility for the cost of the services. Normally, *referrals* will be limited to *HealthKeepers providers. Referrals* are not required for *emergency* care or to visit behavioral health *providers*.

In most cases, *HealthKeepers* will process *your referral* immediately upon receipt of the request from *your PCP,* but no later than 2 working days from *your PCP's* request for the *referral.* A written confirmation will be mailed to *you* within 2 working days of the date the *referral* is processed.

Standing referrals for special conditions and cancer pain management

If *you* have an ongoing *special condition* as determined by *HealthKeepers* that causes *you* to see a *HealthKeepers* physician often, *you* may receive a standing *referral. Your PCP* will refer *you* to another *HealthKeepers* physician for treatment of the ongoing *special condition.* The standing *referral* will allow the *HealthKeepers* physician to treat *you* without obtaining further *referrals.* The *HealthKeepers* physician may authorize *referrals,* procedures, tests, and other medical services related to the *special condition.*

If *you* have been diagnosed with cancer, *you* may receive a standing *referral* to a board-certified physician in pain management or an oncologist for cancer treatment. The board-certified physician in pain management or oncologist will consult on a regular basis with *your PCP* and any oncologist providing care to *you* concerning the plan of pain management. The board-certified physician in pain management or oncologist cannot authorize *referrals* or other health care services.

When referrals are not required

You will receive out-of-plan benefits for *visits* to any provider other than *your PCP* without a *referral.* However, the following services do not require a *referral* from *your PCP:*

- behavioral health services;
- mammograms;
- *outpatient* oral surgery services or *covered services* in conjunction with a dental accident. See the Surgery benefits in the "**What is covered**" section for more information;

- *outpatient* mental health and substance use disorder services;
- *covered services* at a *retail health clinic*;
- obstetrician-gynecologist or nurse midwife care;
- maternity care (routine or complicated);

- routine vision;

- *emergency* care; and
- *urgent care* outside of the *service area.*

Other routine diagnostic procedures (i.e. chest x-rays) may not need a *referral.* The above list of services that do not require a *referral* is for illustrative purposes only. Please work in consult with *your HealthKeepers PCP* in determining referral requirements for services *you* may need.

The advance approval process

HealthKeepers providers are required to obtain prior authorization in order for *you* to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. *HealthKeepers* may determine that a service that was initially prescribed or requested is not *medically necessary* if *you* have not previously tried alternative treatments which are more cost effective.

HealthKeepers will make coverage decisions on services requiring advance approval within 15 days from the receipt of the request. *HealthKeepers* may extend this period for another 15 days if *HealthKeepers* determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, *HealthKeepers* 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 *HealthKeepers* 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 *HealthKeeper'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, the U.S. Department of Labor's Employee Benefits Security Administration that 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 *HealthKeepers* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the experimental nature of the care, *you* are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

HealthKeepers may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in *HealthKeeper's* discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, *we* may select certain qualifying providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. *We* may also exempt *your* claim from medical review if certain conditions apply.

Just because *HealthKeepers* exempts a process, provider or claim from the standards which otherwise would apply, it does not mean that *HealthKeepers* will do so in the future, or will do so in the future for any other provider, claim or *member*. *HealthKeepers* may stop or modify any such exemption with or without advance notice.

You may determine whether a *provider* is participating in certain programs by checking the *provider* directory or contacting the Member Services number on the back of *your* ID card.

We also may identify certain *providers* to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a *provider* is selected under this program, then *we* may use one or more clinical utilization management guidelines in the review of claims submitted by this *provider*, even if those guidelines are not used for all *providers* delivering services to this plan's *members*.

Approvals of care involving an ongoing course of treatment

HealthKeepers 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-*HealthKeepers provider* and need to receive an extension of a previously approved course of treatment, *you* will be required to ask for the extension. *You* should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. *We* will notify *you* of *our* coverage decision within 24 hours of *your* request.

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

will notify *you* in advance of the reduction or termination in sufficient time for *you* to file an internal appeal prior to the reduction or termination.

When you do not use your Primary Care Physician

If *you* decide to seek treatment for a non-*emergency* health condition from a *HealthKeepers provider* or from a non-*HealthKeepers provider* without first obtaining a referral from *your PCP, you* will receive *out-of-plan benefits.* After *you* satisfy a calendar year *deductible, you* are responsible for *your coinsurance* which is a percentage of the *maximum allowed amount,* as stated in the **Summary of benefits.** *You* may be responsible for any charges over *our maximum allowed amount* and this amount will not apply toward *your* annual copayment limit.

Non-HealthKeepers providers

In the event that *you* receive *covered services* from a non-*HealthKeepers provider*, then we reserve the right to make payment of such *covered services* directly to *you,* the non-*HealthKeepers provider,* or any other person responsible for paying the non-*HealthKeepers provider's* charge. In the event that payment is made directly to *you*, *you* have the responsibility to apply this payment to the claim from the non-*HealthKeepers provider*. If *you* receive services from a *non-HealthKeepers* provider without the proper authorization, *you* will receive *out-of-plan benefits*. In addition, *you* may be responsible for any charges over our *maximum allowed amount* and this amount will not apply toward *your* annual *copayment* limit.

Terminated providers

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

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

1. A *member* in the second or third trimester of pregnancy may continue seeing her obstetrician-gynecologist through postpartum care for that delivery.
2. *Members* with life expectancy of six months or less may continue seeing their treating physician.
3. *You* have chosen to receive services on an out-of-plan basis.

Guest Memberships

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

Accessing care in the case of an emergency or urgent care situation

No ***referral*** is necessary in the case of a true *emergency*. *Urgent care situations* in the *service area* require an advance *referral* from *your PCP* in order to be covered. To be eligible for *urgent care* benefits, *you* must obtain *your PCP's referral* in advance.

Please note that not all in-plan *providers* offer all services. For example, some hospital-based labs are not part of *our* Reference Lab Network. In those cases *you* will have to go to a lab in *our* Reference Lab Network to get in-plan benefits. Please call members Services before *you* get services for more information.

The difference between emergency care and urgent care

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

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

Urgent care situations are **usually** marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of *urgent care situations* include high fever, vomiting, sprains or minor cuts. These are not considered *emergencies* and are not covered if *you* go directly to an *emergency* room for treatment without consulting *your PCP*. Contact *your PCP* immediately for instructions on where to obtain *urgent care* treatment.

Note: If *you* cannot contact *your PCP* or are unsure if *your* condition requires *emergency* or *urgent care,* the 24/7 NurseLine is available to help *you* 7 days a week. A registered nurse will discuss *your* symptoms with *you,* recommend an appropriate level of care, and assist *you* in obtaining a *referral* if it is needed.

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

- Medical care is available through *your PCP* 7 days a week, 24 hours a day. If *you* need care after regular office hours *you* may contact the on-call *PCP* or the 24/7 NurseLine. For instructions on how to receive care, call *your PCP* or the 24/7 NurseLine at 800-337-4770.
- If *your* condition is an *emergency, you* should be taken to the nearest appropriate medical facility.
- *Your* coverage includes benefits for services rendered by providers other than *HealthKeepers providers* when the condition treated is an *emergency* as defined in this *EOC*.
- *You* must contact *your PCP* before going to the *urgent care* center or *emergency* room in order to obtain a proper *referral* for *urgent care* or other non-*emergency* services. If *you* are unable to reach *your PCP, you* may call the 24/7 NurseLine at **800-337-4770** for assistance.

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

HealthKeepers does business only within a certain geographic area in the Commonwealth of Virginia. See **The BlueCard Program** below for *covered services* received outside of Virginia. Services outside the *service area* are provided to help *you* if *you* are injured or become ill while temporarily away from the *service area.* In order to receive in-plan benefits for these services, *you* must satisfy any authorization requirements outlined in this EOC and obtain care from a health care provider that has a contractual arrangement with the local Blue Cross and/or Blue Shield licensee in the area where *you* are being treated. **The BlueCard Program** section provides additional details and *you* may locate a contracting provider by visiting www.anthem.com or calling Member Services.

Benefits for continuing or follow-up treatment must be pre-arranged by *your PCP* and provided in the *service area* and are subject to all provisions of this *EOC.*

If you need to access care when *you* are temporarily outside the *service area:*

- *you* should obtain care at the nearest medical facility if *you* have an *emergency* or *urgent care situation;*
- *you* or a representative on *your* behalf, must call the 24/7 NurseLine at 800-337-4770 within 48 hours of the time of the *visit* to notify *HealthKeepers* that services were received;
- *you* will be responsible for payment of charges at the time of *your visit;* and
- *you* should obtain a copy of the complete itemized bill for filing a claim with *HealthKeepers.* For more information on filing claims see **When you must file a claim** on page 55.

Out-of-Area Services

HealthKeepers has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside *HealthKeeper*'s 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 *HealthKeepers* and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside *HealthKeepers*'s service area, you will obtain care from healthcare 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 nonparticipating healthcare Providers. *HealthKeepers*'s payment practices in both instances are described below.

The BlueCard® Program

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

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

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

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

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

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 *HealthKeepers* uses for *your* claim because they will not be applied retroactively to claims already paid.

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

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

You can also access doctors and hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide

Before *you* travel outside the United States, check with *your* group or call customer service at the number on *your* identification card to find out if *your* plan has BlueCard Worldwide benefits. *Your* coverage outside the United States may be different and we suggest:

- Before *you* leave home, call the customer service number on *your* identification card for coverage details.
- Always carry *your* up to date HealthKeepers identification card.

- In an emergency, go straight to the nearest hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a doctor *visit* or hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- *You* need to find a doctor or hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a doctor *visit* or hospital stay, if needed.
- *You* need inpatient care. After calling the Service Center, *you* must also call us to get approval for benefits at the phone number on *your* identification card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- Participating BlueCard Worldwide Hospitals. In most cases, when *you* make arrangements for a hospital stay through BlueCard Worldwide, *you* should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-covered services, deductible, copayments and coinsurance) *you* normally pay. The hospital should send in *your* claim for *you*.
- Doctors and/or non-participating hospitals. *You* will need to pay upfront for outpatient services, care received from a doctor, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then *you* can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The hospital will file *your* claim if the BlueCard Worldwide Service Center arranged *your* hospital stay. *You* will need to pay the hospital for the out-of-pocket costs *you* normally pay.
- *You* must file the claim for outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center. *You* will need to pay the provider and subsequently send an International claim form with the original bills to us.

Claim Forms

You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at http://www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

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

Notification

If *you* are hospitalized as a result of receiving *emergency* services, *you* or a representative on *your* behalf must notify *HealthKeepers* within 48 hours after *you* begin receiving care. Failure to do so may result in denial of benefits. **This applies to services received within or outside the service area.**

Hospital admissions

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

HealthKeepers 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. *HealthKeepers* may extend this period for another 15 days if *HealthKeepers* determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15-day period.

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

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

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *HealthKeeper'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, the U.S. Department of Labor's Employee Benefits Security Administration that 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 *HealthKeepers* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the experimental nature of the care, *you* are entitled to receive upon request, and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to *your* medical condition.

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

The length of *stay* for maternity admissions is determined according to the Newborn's and Mother's Health Protection Act. This federal law allows for 48 hours for vaginal delivery or 96 hours for caesarian section. Admissions for maternity care do not, initially, require Hospital Admission Review.

However, if complications develop and additional days are necessary, Hospital Admission Review is required. We request that *your* doctor contact *HealthKeepers* to establish eligibility and waiting periods.

Out-of-plan
You must initiate pre-admission authorization from *HealthKeepers* if *you* choose to receive *out-of-plan* care. This is necessary for all *out-of-plan* non-*emergency inpatient* admissions including admissions for *mental health and substance abuse* conditions. If authorization is not received from *HealthKeepers, you* will be responsible for all costs (physician, non-physician, and facility) related to the hospital *stay*.

Health plan individual case management

Our health plan individual case management programs (Case Management) help coordinate services for *members* with health care needs due to serious, complex, and/or chronic health conditions. *Our* programs coordinate benefits and educate members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, *your* health plan case management staff. These Case Management programs are separate from any *covered services you* are receiving.

If you meet program criteria and agree to take part, *we* will help *you* meet *your* identified health care needs. This is reached through contact and team work with *you* and/or *your* chosen authorized representative, treating doctor(s), and other providers.

In addition, *we* may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving *you* information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, *we* may provide benefits for alternate care that is not listed as a *covered service*. *We* may also extend *covered services* beyond the benefit maximums of this plan. *We* will make our decision case-by-case, if in *our* discretion the alternate or extended benefit is in the best interest of the member and *HealthKeepers*. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to *you* or to any other *member*. *We* reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify *you* or *your* authorized representative in writing.

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

In addition to the *covered services* listed in this *EOC, we* may provide certain benefits to help *covered persons* manage their chronic health conditions. If *you* have a chronic condition such as diabetes or hypertension, *you* can find out more about these benefits by calling the Member Services number on *your* I.D. card.

Value-added programs

We may offer health or fitness related programs to our members, through which *you* may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not *covered services* under *your* plan but are in addition to plan benefits. As such, program features are not guaranteed under *your* health plan contract and could be discontinued at any time. *We* do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services *you* receive.

Voluntary clinical quality programs

We may offer additional opportunities to assist *you* in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that *you* have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage *you* to get certain care when *you* need it and are separate from *covered services* under your plan. These programs are not guaranteed and could be discontinued at any time. *We* will give *you* the choice and if *you* choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, *you* may receive incentives such as gift cards or retailer coupons, which *we* encourage *you* to use for health and wellness related activities or items. Under other clinical quality programs, *you* may receive a home test kit that allows *you* to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. *You* may also be offered a home visit appointment to collect such specimens and complete biometric screenings. *You* may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If *you* have any questions about whether receipt of a gift card or retailer coupon results in taxable income to *you*, *we* recommend that *you* consult your tax advisor.

Voluntary wellness incentive programs

We may offer health or fitness related program options for purchase by *your* group to help *you* achieve *your* best health. These programs are not *covered services* under *your* plan, but are separate components, which are not guaranteed under this plan and could be discontinued at any time. If *your* group has selected one of these options to make available to all employees, *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. Under other options a group may select, *you* may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If *you* think you might be unable to meet the standard, *you* might qualify for an opportunity to earn the same reward by different means. *You* may contact us at the customer service number on *your* ID card and we will work with *you* (and, if *you* wish, *your* doctor) to find a wellness program with the same reward that is right for *you* in light of *your* health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to *you*. For additional guidance, please consult *your* tax advisor.)

If you changed coverage within the year

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

- If *you* change from one employer's health plan to another employer's health plan during the calendar year, new benefit limitations and out-of-pocket amounts will apply as of *your effective date* of coverage under the new employer's health plan. Amounts that may have accumulated toward specific benefits or out-of-pocket amounts under *your* former employer's health plan will not count under *your* new employer's health plan.

- If *you* do not change employers, but move from coverage other than *HealthKeepers* coverage (issued by any Anthem-affiliated health maintenance organization) to *HealthKeepers* coverage during the calendar year, new benefit limitations and out-of-pocket amounts will apply as of the *effective date* of *your HealthKeepers* coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket amounts under the other coverage will not count under the *HealthKeepers* coverage.

- If *you* do not change employers, but move from one *HealthKeepers* benefit plan or option to another *HealthKeepers* benefit plan or option during the calendar year, any amounts that had accumulated toward the calendar year benefit limitations and out-of-pocket amounts before the change will count under the new *HealthKeepers* benefit plan or option for the remainder of the calendar year.

What is covered

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

The following pages describe the benefits available to *you* under this *EOC*. Keep in mind, in order to receive the highest level of benefits *your* services should be provided or arranged by *your PCP*.

Ambulance service

Medically necessary ambulance services are a covered service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
    - From your home, the scene of an accident or medical emergency to a hospital;
    - Between hospitals, including when we require you to move from an out-of-network hospital to an in-network hospital
    - Between a hospital and a skilled nursing facility or other approved facility.
- For air or water ambulance, you are taken:
    - From the scene of an accident or medical emergency to a hospital;
    - Between hospitals, including when we require you to move from an out-of-network hospital to an in-network hospital
    - Between a hospital and an approved facility.

Ambulance services are subject to medical necessity reviews by us. *Emergency* ambulance services do not require precertification and are allowed regardless of whether the *provider* is an in-network or out-of-network provider.

Non-*Emergency* ambulance services are subject to *medical necessity reviews* by *us*. When using an air ambulance for non-*emergency* transport, we reserve the right to select the air ambulance provider. If *you* do not use the air ambulance provider we select, the out-of-network provider may bill *you* for any charges that exceed the plan's *maximum allowed amount*.

You must be taken to the nearest facility that can give care for *your* condition. In certain cases, we may approve benefits for transportation to a facility that is not the nearest facility.

Benefits also include medically necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if *you* are not taken to a facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger *your* health and *your* medical condition requires a more rapid transport to a facility than the ground ambulance can provide, the plan will cover the air ambulance.

Air ambulance will also be covered if *you* are in an area that a ground or water ambulance cannot reach. Air ambulance will not be covered if you are taken to a hospital that is not an acute care hospital (such as a skilled nursing facility), or if *you* are taken to a physician's office or *your* home.

Hospital to Hospital Transport

If *you* are moving from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger *your* health and if the hospital that first treats cannot give *you* the medical services *you* need. Certain specialized services are not available at all hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain hospitals. To be covered, *you* must be taken to the closest hospital that can treat *you*. Coverage is not available for air ambulance transfers simply because *you, your* family, or *your* provider prefers a specific hospital or physician.

Autism services

Your coverage includes certain treatments associated with autism spectrum disorder (ASD) for dependents from age two through age ten. 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.*

Clinical trial cost

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

Dental Services (All Members/All Ages)

Preparing the Mouth for Medical Treatments

Your plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. *Covered services* include:

- Evaluation
- Dental x-rays

- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an accidental injury under this plan, **unless the chewing or biting results from a medical or mental condition**. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.

Hospitalization for Anesthesia and Dental Procedures

Your plan includes coverage of 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.

Note: *HealthKeepers* **provides coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by HealthKeepers, are not** *covered service.*

Diabetic supplies, equipment, and education

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

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes and hypodermic needles and syringes when received from a *HealthKeepers* 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.

Screenings for gestational diabetes are covered under Preventive care.

Diagnostic tests

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

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

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

- *your* medical condition requires that medical skills be constantly available;
- *your* medical condition requires that medical supervision by *your* doctor is constantly available; or
- diagnostic services and equipment are available only as an *inpatient*.

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

Dialysis

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

Doctor visits and services

Call *your PCP* when *you* are in need of health care services. *Your PCP* may pre-arrange care if *you* need to see a specialty care provider. *Your* coverage provides for:

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

Early intervention services

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

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

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

Emergency room care

Emergency services

Benefits are available in a hospital emergency room for services and supplies to treat the onset of symptoms for an *emergency*, which is defined below.

Emergency (Emergency Medical Condition)

"*Emergency*," or "emergency medical condition" means a medical condition of recent onset and sufficient

severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's mental or physical health in serious danger or, for a pregnant women, placing the women's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be *emergencies* by *us*.

Emergency Care

"*Emergency* care" means a medical exam done in the emergency department of a hospital, and includes services routinely available in the emergency department to evaluate an *emergency* condition. It includes any further medical exams and treatment required to stabilize the patient. "Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta."

If *you* are experiencing an *emergency* please call 911 or visit the nearest hospital for treatment.

Medically necessary services will be covered whether you get care from an in-plan or out-of-plan provider. *Emergency* care you get from an out-of-plan provider will be covered as an in-plan service, but *you* may have to pay the difference between the out-of-plan provider's charge and the *maximum allowed amount,* as well as any applicable *coinsurance*, *copayment* or *deductible*.

The *maximum allowed amount* for *emergency* care from an out-of-plan provider will be the greatest of the following:

a) The amount negotiated with in-plan providers for the *emergency* service;
b) The amount for the *emergency* service calculated using the same method we generally use to determine payments for out-of-plan services but substituting the in-plan cost-sharing for the out-of-plan cost-sharing; or
c) The amount that would be paid under Medicare for the *emergency* service.

If *you* are admitted to the hospital from the *emergency* room, be sure that *you* or *your* doctor calls *us* as soon as possible. *We* will review *your* care to decide if a hospital stay is needed and how many days *you* should stay. See "Hospital Admission Review" in the **How your coverage works** section for more details. If you or *your* doctor do not call *us*, *you* may have to pay for services that are determined to be not *medically necessary*.

Treatment *you* get after your condition has stabilized is not *emergency* care. If *you* continue to get care from an out-of-plan provider, c*overed services* will be covered at the out-of-plan level unless *we* agree to cover them as an authorized service.

If *you* are admitted to the hospital from the *emergency* room, *you* must notify *your PCP* within 48 hours after *you* begin receiving care. The *emergency* room doctor, a relative, or a friend can call for *you.* Failure to do so may result in denial of benefits by *HealthKeepers*.

Home care services

When authorized by *HealthKeepers, we* cover treatment provided in *your* home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat *your* condition. To ensure benefits, *your* doctor must

provide a description of the treatment *you* will receive at home. *Your* coverage includes the following home health services:

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

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

Hospice care services

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

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

Hospital services

Your coverage includes *medically necessary* ambulance services. In an *emergency, HealthKeepers* authorization is not required. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life.

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

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

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

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

Private room

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

Infusion services

When authorized by *HealthKeepers*, *we* cover infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally. See the section "Prescription drugs administered by a medical provider" for more details.

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

Lymphedema

Your coverage includes benefits for expenses incurred in connection with the treatment of **lymphedema.** It does not include massage therapy services at spas or health clubs.

Maternity

Prenatal and newborn care

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

Your benefits include:

- home *setting* covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital *stay*;
- prenatal, postnatal and postpartum care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- *home care services* for postnatal care;
- circumcision of a covered male dependent;
- services for the evaluation and treatment of infertility for you or your covered spouse. Artificial insemination benefits are limited to **[two/four/six]** procedures per lifetime; **[and]**
- use of the delivery room and care for normal deliveries; and
- **fetal screenings**, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

Future Moms

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

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

Note: See **If your family changes** in the **Changing your coverage** section for details on when and how to enroll a newborn.

Medical equipment (durable)

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

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

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

Medical devices and appliances

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

Examples of covered medical devices include:

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

Medical formulas

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

Medical supplies and medications

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

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

Injectable medications

Your coverage includes benefits for self-administered injectable medications obtained through a retail pharmacy or administered by a *HealthKeepers provider*. Please see "Prescription drugs administered by a medical provider" and "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" at the end of **What is Covered** for detailed information.

Prosthetic devices and components

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

Mental health or substance use disorder treatment

Accessing *your* mental health services and substance use disorder 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. All *members* can select any mental health and substance use disorder *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.

Covered services include the following:

- **Inpatient services** in a hospital or any facility that *we* must cover per state law. *Inpatient* benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, electroconvulsive therapy, detoxification, and rehabilitation.

- **Outpatient services** including office visits and treatment in an outpatient department of a hospital or *outpatient* facility, such as partial hospitalization programs and intensive *outpatient* programs. *Covered services* include individual psychotherapy, group psychotherapy, psychological testing and medication management *visits* (*visits* to *your* physician to make sure that the medication *you* are taking for a mental health or substance use disorder is working and the dosage is right for *you*).

- **Residential treatment** which is specialized 24-hour treatment in a licensed residential treatment center or intermediate care facility. It offers individualized and intensive treatment and includes:
  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, and education.

Examples of *providers* from whom you can receive *covered services* include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day/visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on any medical surgical benefits may not impost such day or visit limits on mental health and substance use disorder benefits offered under the plan. Also, the plan may not impose *deductibles, copayment, coinsurance,* and out-of-pocket expenses on mental health and substance use disorder benefits that are more restrictive than *deductibles, copayment, coinsurance* and out-of-pocket expenses applicable to other medical and surgical benefits. *Medical necessity* criteria are available upon request.

Obstetrician-gynecologist physician services

All female *members* may receive services from an obstetrician-gynecologist who is a *HealthKeepers* physician without a *referral* for the care of or related to the female reproductive system and breasts. The obstetrician-gynecologist must obtain authorization from *HealthKeepers* for *inpatient* hospital services and *outpatient* surgery.

Preventive Care

Preventive care includes screenings and other services for adults and children with no current symptoms or history of a medical condition associated with the screening service.

Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic services" benefit, not this benefit for that particular problem or condition.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no *deductible*, *copayments* or *coinsurance* when you use an *in-network provider*. That means we cover 100% of the *maximum allowed amount*. *Covered services* fall under the following broad groups:

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 (including infant hearing screening);
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - Women's contraceptives including all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization treatments, and counseling. Contraceptive coverage includes generic and single-source brand drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source brand drugs will be covered as a preventive care benefits when *medically necessary,* otherwise they will be covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy."
    - Breastfeeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy.
    - Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
    - Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of pap smear results.
    - Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.
    - Screening and counseling for interpersonal and domestic violence.
    - Well women visits.
5. Preventive care services for tobacco cessation for *members* age 18 and older as recommended by the United States Preventive Services Task Force including:
    - Counseling
    - Prescription drugs
    - Nicotine replacement therapy products when prescribed by a *provider,* including over the counter (OTC) nicotine gum, lozenges and patches.

    Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.
6. *Prescription drugs* and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a *provider* including:
    - Aspirin
    - Folic acid supplement
    - Vitamin D supplement
    - Iron supplement
    - Bowel preparations

    Please note that certain age and gender and quantity limitations apply.
7. Counseling services related to general nutrition.

You may call Member Service at 800-451-1527 for additional information about these services or view the federal government websites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and

http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

In addition to the federal requirement above, preventive coverage also includes the following *covered services* as required by state law:

- Routine screening mammograms
- Routine annual pap test including coverage for testing performed by any FDA-approved gynecologic cytology screening technologies;
- Routine annual prostate specific antigen testing and digital rectal exams for male enrollees age 40 and older.

Skilled nursing facility stays

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

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

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

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

Smoking cessation

Please see the "Preventive care" section in this *EOC*.

Spinal manipulation and manual medical therapy service

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

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

Out-of-plan

If *you* wish to receive care from a non-ASHG provider, contact ASHG directly for authorization. If authorization is not received, *you* will be responsible for all costs related to these services.

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

Surgery

General surgery

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

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is medically necessary to attain functional capacity of the affected part.
- Oral /surgical correction of accidental injuries as indicated in the "dental services" section.
- 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.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Organ and tissue transplants, transfusions

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

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

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

To maximize your benefits, *you* should call our transplant department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant.

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

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

Therapy

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

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

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

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

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

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

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

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

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

Vision correction after surgery or accident

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

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

Prescription drugs administered by a medical provider

Your plan covers *prescription drugs* when they are administered to *you* as part of a doctor's visit, home care visit, or at an *outpatient* facility. This includes *drugs* for infusion therapy, chemotherapy, *specialty drugs*, blood products, injectables, and any drug that must be administered by a *provider*. This section applies when *your provider* orders the drug and administers it to *you*.

Benefits for *drugs* that *you* get at a *pharmacy* (i.e., self-administered drugs) are not covered under this section. Benefits for those drugs are described in the "*Prescription drug* benefit at a retail or home delivery (mail order) pharmacy".

Note: When *prescription drugs* are covered under this benefit, they will not also be covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" benefit. Also, if *prescription drugs* are covered under the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy benefit, they will not be covered under this benefit.

Important details about prescription drug coverage

Your plan includes certain features to determine when *prescription drugs* should be covered, which are described below. As part of these features, *your* prescribing doctor may be asked to give more details before *we* can decide if the *drug* is *medially necessary*. *We* may also set quantity and/or age limits for specific *prescription drugs* or use recommendations made as part of *our* Medical Policy and Technology Assessment Committee and/or *pharmacy and therapeutics process*.

Prior authorization

Prior authorization may be needed for certain *prescription drugs* to make sure proper use and guidelines for *prescription drug* coverage are followed. *We* will contact *your provider* to get the details *we* need to decide if prior authorization should be given. *We* will give the results of *our* decision to both *you* and *your provider*.

If prior authorization is denied *you* have the right to file a grievance as outlined in the "Grievance/appeal and eternal review procedures" section of this *EOC*.

For a list of *drugs* that need prior authorization, please call the phone number on the back of *your* Identification Card. The list will be reviewed and updated from time to time. Including a *drug* or related item on the list does not guarantee coverage under *your* plan. *Your provider* may check with *us* to verify *drug* coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which *brand* or *generic drugs* are covered under the plan.

Step therapy
Step therapy is a process in which *you* may need to use one type of drug before *we* will cover another. *We* check certain *prescription drugs* to make sure that proper prescribing guidelines are followed. These guidelines help *you* get high quality and cost effective *prescription drugs*. If a doctor decides that a certain drug is needed, prior authorization will apply.

Therapeutic substitution
Therapeutic substitution is an optional program that tells *you* and *your* doctors about alternatives to certain prescribed *drugs*. *We* may contact *you* and *your* doctor to make *you* aware of these choices. Only *you* and *your* doctor can determine if the therapeutic substitute is right for *you*. *We* have a therapeutic drug substitutes list, which *we* review and update from time to time. For questions or issues about therapeutic *drug* substitutes, call Member Services at the phone number on the back of *your* Identification Card.

Prescription drug benefit at a retail or home delivery (mail order) pharmacy

Your plan also includes benefits for *prescription drugs you* get at a retail or mail order *pharmacy*. *We* use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of retail *pharmacies*, a home delivery (mail order) *pharmacy*, and a specialty *pharmacy*. The PBM works to make sure *drugs* are used properly. This includes checking that prescriptions are based on recognized and appropriate doses and checking for *drug* interactions or pregnancy concerns.

Note: Benefits for *prescription drugs*, including *specialty drugs*, which are administered to *you* in a medical setting (e.g., doctor's office, home care visit, or *outpatient* facility) are covered under the "Prescription drugs administered by a medical provider" benefit. Please read that section for important details.

Prescription drug benefits
As described in the "Prescription drugs administered by a medical provider" section, *prescription drug* benefits may depend on reviews to decide when *drugs* should be covered. These reviews may include prior authorization, step therapy, use of a *prescription drug* list, therapeutic substitution, day/supply limits, and other utilization services. *Your* in-network pharmacist will be told of any rules when *you* fill a prescription, and will be also told about any details *we* need to decide benefits.

Covered prescription drugs
To be a *covered service*, *prescription drugs* must be approved by the Food and Drug Administration (FDA) and, under federal law, require a prescription. *Prescription drugs* must be prescribed by a licensed *provider* and *you* must get them from a licensed *pharmacy*.

Benefits are available for the following:

- *prescription legend drugs* from either a retail *pharmacy* or the PBM's home delivery *pharmacy*;
- *Specialty drugs*;

- self-administered *drugs*. These are *drugs* that do not need administration or monitoring by a *provider* in an office or facility. Injectables and infused *drugs* that need *provider* administration and/or supervision are covered under the "Prescription drugs administered by a medical provider" benefit;
- oral chemotherapy drugs when administration or monitoring by a *provider* or in an office or a facility is not required;
- self-injectable insulin and supplies and equipment used to administer insulin;
- self-administered contraceptives, including oral contraceptive *drugs*, self-injectable contraceptive *drugs*, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive care" benefit. Please see that section for more details;
- special food products or supplements when prescribed by a doctor if *we* agree they are *medically necessary*;
- flu shots (including administration). These will be covered under the "Preventive care" benefit.
- immunizations required by the "Preventive care" benefit.
- immunizations administered by a licensed pharmacist as allowed by law.
- *prescription drugs* that help *you* stop smoking or reduce *your* dependence on tobacco products. These drugs will be covered under the "Preventive care" benefit;
- compound drugs when a commercially available dosage form of a *medically necessary* medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a prescription for a *member* age 18 or older. These products will be covered under the "Preventive care" benefit;
- *prescription drugs* used to treat infertility;

We 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.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Additionally, benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Please see "Experimental/investigative" in the "Definitions" section for additional information about the exception criteria and requirements for these coverage situations.

Where you can get prescription drugs

In-network pharmacy

You can visit one of the local retail *pharmacies* in *our* network. Give the *pharmacy* the prescription from *your* doctor and *your* Identification Card and they will file *your* claim for *you*. *You* will need to pay any *copayment*, *coinsurance*, and/or *deductible* that applies when *you* get the *drug*. If *you* do not have *your* Identification Card, the *pharmacy* will charge *you* the full retail price of the prescription and will not be able to file the claim for *you*. *You* will need to ask the *pharmacy* for a detailed receipt and send it to *us* with a written request for payment.

Important note: If *we* determine that *you* may be using *prescription drugs* in a harmful or abusive manner, or with harmful frequency, *your* selection of in-network pharmacies may be limited. If this happens, *we* may require *you* to select a single in-network pharmacy that will provide and coordinate all pharmacy services. Benefits will only be paid if *you* use the single in-network pharmacy. *We* will contact *you* if *we* determine that use of a single in-network pharmacy is needed and give *you* options as to which in-network pharmacy *you* may use. If *you* do not select one of the in-network pharmacies *we* offer within 31 days, *we* will select a single in-network pharmacy for *you*. If *you* disagree with *our* decision, *you* may ask *us* to reconsider it as outlined in the "Grievance/Appeal Process" section of this *EOC*.

Specialty pharmacy

If *you* need a *specialty drug*, you or your doctor should order it from the PMB's specialty *pharmacy*. *We* keep a list of *specialty drugs* that may be covered based upon clinical findings from the *pharmacy and therapeutics (P&T) process*, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's specialty *pharmacy* has dedicated patient care coordinators to help *you* take charge of *your* health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer *your* questions about *specialty drugs*.

When *you* use the PBM's specialty *pharmacy* a patient care coordinator will work with *you* and *your* doctor to get prior authorization and to ship *your specialty drugs* to *you* or *your* doctor's office. *Your* patient care coordinator will also tell *you* when it is time to refill *your* prescription.

You can get a list of covered *specialty drugs* by calling Member Services at the phone number on the back of *your* Identification card or check *our* website at www.anthem.com.

Home delivery pharmacy

The PBM also has a home delivery *pharmacy* which lets *you* get certain *drugs* by mail if *you* take them on a regular basis. *You* will need to contact the PBM to sign up when *you* first use the service. *You* can mail written prescriptions from *your* doctor or have *your* doctor send the prescription to the home delivery *pharmacy*. *Your* doctor may also call the home delivery *pharmacy*. *You* will need to send in any *copayments*, *deductible*, or *coinsurance* amounts that apply when *you* ask for a prescription or refill.

Retail maintenance pharmacy

You may also obtain up to a 90-day supply of covered *maintenance medications* through a retail pharmacy participating in our retail *maintenance* network. Ask *your* doctor to prescribe a 90-day supply of *your* medications, plus refills. Take your prescription to a retail pharmacy that participates in our retail *maintenance* network.

A *maintenance medication* is a *drug you* take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If *you* are not sure if the *prescription drug you* are taking is a *maintenance medication,* please call Member Services at the number on the back of *your* Identification Card or check *our* website at www.anthem.com for more details.

Out-of-network pharmacy

You may also use a *pharmacy* that is not in *our* network. *You* will be charged the full retail price of the *drug* and *you* will have to send *your* claim for the *drug* to *us* (out-of-network *pharmacies* won't file the claim for *you*). *You* can get a claims form from *us* or the PBM. *You* must fill in the top section of the form and ask the out-of-network *pharmacy* to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, *you* must attach a detailed receipt to the claim form. The receipt must show:

- name and address of the out-of-network *pharmacy*;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the *drug*;
- cost of the *drug*;
- quantity (amount) of each covered *drug* or refill dispensed.

You must pay the full retail price of the drug. Reimbursement to you is based on the *maximum allowed amount* as determined by our normal or average contracted rate with network *pharmacies* on or near the date of service.

Services of non-participating pharmacies

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

What you pay for prescription drugs

Tiers

Your share of the cost for *prescription drugs* may vary abased on the tier the *drug* is in.

- Tier 1 *drugs* have the lowest *coinsurance* or *copayment*. This tier contains low cost and preferred *drugs* that may be *generic*, single source brand *drugs*, or multi-source brand drugs*, or* specialty *drugs* (including therapeutic biological products).

- Tier 2 *drugs* have a higher *coinsurance* or *copayment* than those in Tier 1. This tier may contain preferred *drugs* that may be *generic*, single source, or multi-source brand *drugs*, *or* specialty *drugs* (including therapeutic biological products).
- Tier 3 *drugs* have a higher *coinsurance* or *copayment* than those in Tier 2. This tier may contain higher cost preferred and non-preferred *drugs* that may be *generic*, single source or multi-source brand *drugs, or* specialty *drugs* (including therapeutic biological products).

We assign *drugs* to tiers based on clinical findings from the *pharmacy and therapeutics (P&T) process*. *We* retain the right, at *our* discretion, to decide coverage for doses and administration (i.e., oral, injection, topical, or inhaled). *We* may cover one form of administration instead of another, or put other forms of administration in a different tier. *We* will provide at least 30 day prior written notice of any modification to a formulary that results in the movement of a *prescription drug* to a tier with higher cost-sharing requirements.

Note: *We* and/or *our* designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain *drug* purchases under this plan. These amounts will be retained by *us*. They will not be applied to *your deductible,* if any, or taken into account in determining *your copayments* or *coinsurance*.

Prescription drug list

We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved *drugs* that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain *drugs* if they are not on the Prescription Drug List.

The drug list is developed by *us* based upon clinical findings, and where proper, the cost of the *drug* relative to other *drugs* in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, *generic drugs,* the use of one *drug* over another by *our members*, and where proper, certain clinical economic reasons.

We retain the right, at *our* discretion, to decide coverage for doses and administration methods (i.e., by oral, injection, topical, or inhaled) and may cover one form of administration instead of another as *medically necessary*.

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 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.

Additional features of your prescription drug pharmacy benefit

Day supply and refill limits

Certain day supply limits apply to *prescription drugs* as listed in the **Summary of benefits**. In most cases, *you* must use a certain amount of *your* prescription before it can be refilled. In some cases *we* may let *you* get an early refill. For example, *we* may let *you* refill *your* prescription early if it is decided that *you* need a larger dose. *We* will work with the *pharmacy* to decide when this should happen.

If *you* are going on vacation and *you* need more than the day supply allowed, *you* should ask *your* pharmacist to call *our* PBM and ask for an override for one early refill. If *you* need more than one early refill, please call Member Services at the number on the back of *your* Identification Card.

Half-tablet program

The half-tablet program lets *you* pay a reduced *copayment* on selected "once daily dosage" *drugs* on *our* approved list. The program lets *you* get a 30-day supply (15 tablets) of the higher strength *drug* when the doctor tells *you* to take a "½ tablet daily." The half-tablet program is strictly voluntary and *you* should talk to *your* doctor about the choice when it is available. To get a list of the *drugs* in the program call the number on the back of *your* Identification Card.

Split fill dispensing program

The split fill dispensing program is designed to prevent and/or minimize wasted *prescription drugs* if *your prescription drugs* or dose changes between fills, by allowing only a portion of *your* prescription to be filled at our specialty pharmacy. This program also saves *you* out of pocket expenses. The *prescription drugs* that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. *You* can access the list of these *prescription drugs* by calling the toll-free number on *your* member ID card or log onto the website at www.anthem.com

Special programs

Except when prohibited by federal regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective prescription drugs including generic drugs, home delivery drugs, over the counter drugs or preferred products. Such programs may reduce or waive copayments or coinsurance for a limited time.

What is not covered (Exclusions)

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

A

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

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

B

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

C

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

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

D

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

- shortening or lengthening of the mandible or maxillae for cosmetic purposes;
- surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services;
- dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia;
- medications to treat periodontal disease;

- treatment of natural teeth due to diseases;
- treatment of natural teeth due to accidental injury, unless you submitted a treatment plan to *HealthKeepers* for prior approval. No approval of a plan of treatment by *HealthKeepers* is required for emergency treatment of a dental injury;
- chewing and biting related injuries unless the chewing or biting results from a medical or mental condition;
- restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth;
- extraction of either erupted or impacted wisdom teeth; and
- anesthesia and hospitalization for dental procedures and services except as specified in the What is covered section of this EOC.

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

E

Your coverage does not include benefits for services or supplies primarily for **educational**, vocational, or self management/training purposes,except as otherwise specified in this *EOC* or when received as a part of covered preventive care.

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

F

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

- services for interruption of pregnancy including medications to induce abortions, except when deemed as *medically necessary;*
- in vitro fertilization or any other types of artificial or surgical means of conception; or
- any services or supplies provided to a person not covered under this *EOC* in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- non-prescription contraceptive devices; or
- services to reverse voluntarily induced sterility.

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

- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;

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

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 the *EOC*.

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

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

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

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

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 in the **What is covered** section of this EOC.

M

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

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

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

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

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

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

- *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, for the treatment of an eating disorder, or when received as a part of covered preventive care.

Your coverage does not include benefits for **nutritional and/or dietary supplements**, except as provided under this *EOC* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

O

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

Your coverage does not include benefits for **organ or tissue transplants,** including complications caused by them, except as outlined in the **What is covered** section of this *EOC*.

P

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

R

Your coverage does not include benefits for rest cures, custodial, **residential,** or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether *you* receive active 24-hour skilled professional nursing care, daily physician *visits,* daily assessments, and structured therapeutic services.

S

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

- not listed as covered under this *EOC;*
- not prescribed, performed, or directed by a provider licensed to do so;

- services received from *providers* not licensed by law to provide *covered services* defined in this *EOC*. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers**;**
- received before the *effective date* or after a *member's* coverage ends;
- telephone consultations, charges for not keeping appointments, charges for completing claim forms, or other such charges;
- 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; or
- benefits for charges from stand-by physicians in the absence of covered services being rendered.

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

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

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

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

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

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

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

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

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

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

- any treatment or service not authorized by ASHG;

- services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment;
- laboratory tests, x-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate, or classified as experimental or in the research state;
- diagnostic scanning, including magnetic resonance imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography;
- educational programs, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing;
- air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; or
- vitamins, minerals, nutritional supplements, or any other similar type products.

T

Your coverage does not include benefits for the following **therapies:**

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children from birth to age three who qualify for Early Intervention services;
- group speech therapy;
- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

Your coverage does not include benefits for non-interactive **telemedicine services** such as audio-only telephone conversations, electronic mail message, facsimile transmissions or online questionnaire.

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 or accidental injury;
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury;
- sunglasses or safety glasses accompanying frames of any type;
- 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 plan does not cover **waived cost shares out-of-plan** for any service for which *you* are responsible under the teams of this plan to pay a *copayment, coinsurance* or *deductible,* and the *copayment, coinsurance* or *deductible* is waived by an out-of-plan *provider*.

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

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

What's not covered under your prescription drug retail or home delivery (mail order) pharmacy benefit

In addition to the above exclusions, certain items are not covered under the prescription drug retail or home delivery (mail order) pharmacy benefit:

Administration charges - Charges for the administration of any drug except for covered immunizations as approved by *us* or the PBM.

Compound drugs Compound *drugs* unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

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

Delivery charges - Charges for delivery of *prescription drugs*.

Drugs given at the provider's office/facility - Drugs *you* take at the time and place where *you* are given them or where the prescription order is issued. This includes samples given by a doctor. This exclusion does not apply to drugs used with a diagnostic services, drugs given during chemotherapy in the office, or drugs covered under they medical supplies benefit – they are *covered services*.

Drugs not on the Anthem prescription drug list (a formulary) *You* can get a copy of this list by calling *us* or visiting *our* website at www.anthem.com. If *you* or *your* doctor believes *you* need a certain prescription drug not on the list, please refer to "Prescription Drug List" in the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" section at the end of the **What is covered** section for details on requesting an exception.

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

Drugs over quantity or age limits. Drugs in quantities which are over the limits set by the plan, or which are over any age limits set by *us*.

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

Infertility drugs. Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).

Items covered as durable medical equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit may be covered under the Medical equipment (durable) or Medical supplies benefit. Please see that section for details.

Items covered under the medical supplies and medications benefit. Allergy desensitization products or allergy serum. While not covered under the "Prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy" benefit, these items may be covered under the "Medical supplies and medications" benefit. Please see that section for more details.

Mail order providers other than the PBM's home delivery mail order provider. *Prescription drugs* dispensed by any mail order provider other than the PBM's home delivery mail order provider, unless *we* must cover them by law.

Non-approved drugs. Drugs not approved by the FDA.

Off label use. The exception to this Exclusion is described in "Covered Prescription Drugs" in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

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

Over-the-counter items Drugs, devices and products, or prescription legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product. This includes prescription legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over-the-counter products that *we* must cover as a preventive care benefit under federal law with a prescription.

Sex change drugs. Drugs for sex change surgery.

Sexual dysfunction drugs. Drugs used to treat sexual or erectile problems.

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

Weight loss drugs. Any drug used mainly for weight loss.

Claims and payments

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

Calendar year deductible

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

What you will pay

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

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

Annual limit

Calendar year limit

The Summary of benefits lists the *in-plan* and *out-of-plan* calendar year limits for *copayments*, *coinsurance* or *deductible* (if any). The *in-plan* and *out-of-plan* calendar year limits are separate and amounts applied to one do not apply to the other. If a *member* reaches the *in-plan* calendar year limit, that *member* will no longer be required to pay additional *copayments*, *coinsurance* or *deductible* (if any) for *in-plan* services for the remainder of that calendar year. If a *member* reaches the *out-of-plan* calendar year limit, that *member* will no longer be required to pay additional *copayments*, *coinsurance* or *deductible* (if any) for *out-of-plan* services for the remainder of that calendar year. When a *member* reaches *the in-plan* or *out-of-plan* calendar year limit, they will be notified by *HealthKeepers* within 30 days.

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

What does not count toward this limit

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

- routine vision services for members age 19 and older;

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

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

How HealthKeepers pays a claim

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

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

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

How *we* pay a claim takes into account the *maximum allowed amount* for the service, the participating 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 explained in the sections that follow. For the purposes of these sections, *providers* also include *facilities.*

Maximum Allowed Amount

General

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

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

You will be required to pay a portion of the *maximum allowed amount* to the extent *you* have not met *your deductible, copayment* or *coinsurance,* if any. In addition, *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 processing rules to the claim submitted for those *covered services*. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect *our* determination of the *maximum allowed amount. Our* application of these rules does not mean that the *covered services you* received were not *medically necessary*. It means *we* have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, *your* provider may have submitted the claim using several procedure

codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, *our* payment will be based on a single *maximum allowed amount* for such single procedure code rather than a separate *maximum allowed amount* for each billed code.

"Per diem amount" means an all inclusive fixed payment amount for each day of admission in an inpatient facility.

Maximum allowed amount for multiple procedures

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

Provider Network Status

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

Providers who are not in the *HealthKeepers* network are non-*HealthKeepers providers*. When *you* receive *covered services* from a non-*HealthKeepers provider* the *maximum allowed amount* will be one of the following as determined by us:

1. An amount based on our non-*HealthKeepers 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: statewide average reimbursement amounts that *HealthKeepers* previously has paid for similar claims in the state of Virginia, reimbursement amounts accepted by like/similar providers contracted with *HealthKeepers,* reimbursement rates accepted by providers under the last network contract in effect with *HealthKeepers,* 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 reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the *maximum allowed amount* upon the level and/or method of reimbursement used by the CMS, *HealthKeepers* will update such information, no less than annually; 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 negotiated by *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 based on or derived from the total charges billed by the non-*HealthKeepers provider*.

A per diem amount may be used in calculating the maximum allowed amount for inpatient facility services. When calculating these amounts, the charges for non-*covered services* are subtracted from the per diem amount.

Unlike *HealthKeepers providers,* non-*HealthKeepers providers* may send *you* a bill and collect for the amount of the provider's charge that exceeds *our maximum allowed amount. You* are responsible for paying the difference between the *maximum allowed amount* and the amount the provider charges. This amount can be significant. Please call Member Services for help in finding a *HealthKeepers provider* or visit *our* website at www.anthem.com.

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

Member cost share

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

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.

HealthKeepers 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. The *maximum allowed amount* for *inpatient facility* services may be based on a per diem. When calculating these amounts, the charges for non-*covered services* are subtracted from the per diem.

Authorized Services

In some circumstances, such as where there is no *HealthKeepers provider* available for the *covered service, we* may authorize reimbursement for a claim for a *covered service you* receive from a non-*HealthKeepers* provider. In such circumstance, *you* must contact *us* in advance of obtaining the *covered services.* If *we* authorize a *covered service you* may still be liable for the difference between the *maximum allowed amount* and the non-*HealthKeepers* provider's charge. Please contact Member Service for authorized services information or to request authorization.

Example: Assume *you* require the services of a specialty provider; but there is no *HealthKeepers provider* for that specialty in *your* area. *You* contact *us* in advance of receiving any *covered services* and *we* authorize *you* to go to an available non-*HealthKeepers* provider for that *covered service*.

The *maximum allowed amount* for the *covered service* is $500 and the specialty non-*HealthKeepers provider's* charge is $800. *You* may be responsible for the difference between $500 and $800.

Payment innovation programs

We pay in-network providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These programs may vary in methodology and subject area of focus and may be modified by *us* from time to time, but they will be generally designed to tie a certain portion of an in-network provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, in-network providers may be required to make payment to *us* under the program as a consequence of failing to meet these pre-defined standards.

The programs are not intended to affect your access to health care. The program payments are not made as payment for specific *covered services* provided to *you*, but instead, are based on the in-network provider's achievement of these pre-defined standards. *You* are not responsible for any *copayment* or coinsurance amounts related to payments made by *us* or to *us* under the program(s), and *you* do not share in any payments made by in- network providers to *us* under the program(s).

Claims Review

We have processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from out-of-plan providers could be balanced billed by the out-of-plan provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

Non-participating providers and facilities

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

In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-*HealthKeepers* provider.

When you must file a claim

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

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

If *you* receive *out-of-plan* services, *you* must submit *your* claims within 180 days from the date services are received. Claims will not be processed and will be denied if they are submitted more than 180 days from the date of service, except in the absence of legal capacity of the *member*.

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

1. Call 800-451-1527 to order a claim form.
2. Complete and sign the claim form. Attach all itemized bills for *covered services*. Each itemized bill must contain the following:
   - name and address of the person or organization providing services or supplies;
   - name of the patient receiving services or supplies;
   - date services or supplies were provided;
   - the charge for each type of service or supply;
   - a description of the services or supplies received; and
   - a description of the patient's condition (diagnosis).
3. Send the completed claim form and itemized bill(s) to:

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

When your claim is processed

Once a claim has been processed, if *your* portion of the bill is anything other than zero or equal to a flat copayment amount, a paper copy of the Explanation of Benefits (EOB) statement will be mailed to *you* to explain *your* responsibility. In the event that *your* portion of the bill is zero or equal to a flat *copayment* amount, the paper copy will not be mailed, but will be available to *you* online at www.anthem.com. If you do not have access to the Internet, *you* may contact Member Services to arrange for a printed copy.

In processing *your* claim, *HealthKeepers* 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. *HealthKeepers* may extend this period for another 15 days if *HealthKeepers* determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 30-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, *HealthKeepers* will make its decision within 2 working days of its receipt of the medical information needed to process the claim.

HealthKeepers 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 *HealthKeepers* within either 12 months of the date of service or 45 days from the date you were notified that the information is needed, whichever is later. Once *your* claim has been processed by *HealthKeepers*, *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 *HealthKeeper's* appeal procedures and applicable time limits; and
- the availability of, and contact information for, the U.S. Department of Labor's Employee Benefits Security Administration that 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 *HealthKeepers* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

Recovery of overpayments

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

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

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

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

When you are covered by more than one health plan

Coordination of benefits ("COB")

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

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

Primary coverage and secondary coverage

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

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

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

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

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

If Medicare Part D provides *your* primary coverage for *outpatient prescription drugs* provided by a pharmacy, *we* first calculate the amount that would have been payable had *HealthKeepers* 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 *HealthKeepers* would have paid if it had been primary.

Right of recovery provision

Immediately upon paying or providing any benefit under *HealthKeepers*, *your* health plan shall be subrogated to all rights of recovery a *member* has against any party potentially responsible for making any payment to a member due to a *member's* injuries or illness, to the full extent of benefits provided or to be provided by *HealthKeepers*.

In addition, if a *member* receives any payment from any potentially responsible party as a result of an injury or illness, *your* health plan has the right to recover from, and be reimbursed by, the member for all amounts *HealthKeepers* has paid and will pay as a result of that injury or illness, up to and including the full amount the member receives from all potentially responsible parties. The *member* agrees that if he/she receives any payment from any potentially responsible party as a result of an injury or illness, he/she will serve as a constructive trustee over the funds. Failure to hold such funds in trust will be deemed a breach of the *member's* fiduciary duty to the health plan.

Further, your health plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a *member* receives from a third party, the third party's insurer or any other source as a result of the *member's* injuries. The lien is in the amount of benefits paid by *your* health plan for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a *member* due to a *member's* injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The *member* acknowledges that *HealthKeepers* recovery rights are a first priority claim against all potentially responsible parties and are to be paid to *HealthKeepers* before any other claim for the *member's* damages. *HealthKeepers* shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to *HealthKeepers* will result in a recovery to the *member* which is insufficient to make the *member* whole or to compensate the *member* in part or in whole for the damages sustained. It is further agreed that *HealthKeepers* is not required to participate in or pay court costs or attorney fees to the attorney hired by the *member* to pursue the *member's* damage claim.

The terms of this entire right of recovery provision shall apply and *HealthKeepers* is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the *member* identifies the medical benefits

HealthKeepers provided. *HealthKeepers* is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The *member* shall fully cooperate with *HealthKeepers* efforts to recover its benefits paid. It is the duty of the member to notify *HealthKeepers* within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the *member*. The *member* shall provide all information requested by *HealthKeepers* or its representative including, but not limited to, completing and submitting any applications or other forms or statements as *HealthKeepers* may reasonably request. Failure to provide this information shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against the *member*.

The *member* shall do nothing to prejudice *HealthKeepers* recovery rights as herein set forth. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by *HealthKeepers*.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the *member* and *HealthKeepers* agree that *HealthKeepers* shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The *member* agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as *HealthKeepers* may elect. Upon receiving benefits under *HealthKeepers*, the *member* hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Changing your coverage

Who is eligible for coverage

Subscriber
A *subscriber* is eligible for coverage if he/she resides or works in the *service area* and after he/she satisfies the employer's eligibility requirements. The employer will inform the *subscriber* of the *effective date*, which is agreed upon by *HealthKeepers* and the employer.

The subscriber's eligible dependents
Eligible *dependents* include:

- the *subscriber's* legally married spouse;
- the *subscriber's* children age 26 or younger which includes:
- the *subscriber's* newborn, natural child, or child placed with *subscriber* for adoption;
- the *subscriber's* stepchild; and
- any other child for whom the *subscriber* has legal guardianship or court-ordered custody.

The age limit for enrolling children 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 intellectual disability, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the *subscriber* provides proof of handicap and dependence at the time of enrollment.

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

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

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

- Employee only
- Employee and family

When you may enroll

You may enroll:

- **During the initial enrollment period**
  The *subscriber* may enroll any eligible *dependents* by completing a *HealthKeepers* application to be sent to ***HealthKeepers*** by the employer. No person is eligible to re-enroll in *HealthKeepers*

who has coverage terminated as described in **Termination for cause** in the **After Coverage Ends** Section.

- **During open enrollment periods approved by HealthKeepers**
  The coverage of people who enroll during the employer's open enrollment period is effective as agreed upon by the employer and *HealthKeepers* in the Group Enrollment *Agreement*.
- **During a special enrollment period**
  The *subscriber* may have chosen to decline coverage for himself/herself and/or his/her dependents under this health plan when the *subscriber* could have enrolled for it because of coverage under another health plan.

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

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

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

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

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

If your family changes

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

Marriage

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

Newborn dependents
A newborn dependent may be covered from the moment of birth. The *subscriber* must submit a completed application and the appropriate premium amount, if any, to *HealthKeepers* within 31 days of the newborn's birth. If an application along with any appropriate premium amount is not received by *HealthKeepers* within 31 days of birth, the child will not be eligible to be added to the *subscriber's* coverage until the next open enrollment period.

Adopted dependents
When a child has been placed with a *subscriber* for adoption, that child is eligible for dependent coverage from the date of the adoption or placement. However, application for coverage must be submitted within 31 days from the date of eligibility, along with proof that the adoption is pending and any appropriate premium amount. If a newborn infant is placed for adoption with the *subscriber* within 31 days of birth, the child shall be considered a newborn child of the *subscriber,* and coverage may be effective from the date of the child's birth. If an application, along with any premium amount, is not received by *HealthKeepers* within 31 days of the adoption or placement for adoption, the child will not be eligible to be added to the *subscriber's* coverage until the next open enrollment period.

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

HealthKeepers may periodically require proof of dependency.

Note: Any dependent, including a newborn child who is not enrolled in ***HealthKeepers*** within 31 days after becoming eligible, may not enroll until the employer's next open enrollment period.

Other changes that require notification

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

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

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

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

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

After coverage ends

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

Termination for cause

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

a. If *you* allow someone to use *your* identification card or *you* use another *member's* card *HealthKeepers* may recall the card and terminate *your* coverage upon 31 days written notice.

b. *You* represent that all information contained in applications, questionnaires, forms, or statements submitted *HealthKeepers* is true, correct, and complete, and if *you* furnished incorrect or incomplete information which constitutes a material misrepresentation, then *your* coverage may be terminated upon written notice. *Members* terminated for this reason will be responsible to pay charges for all services provided to the *member* that are related to this incorrect or incomplete information.

c. If *you* are guilty of fraud, gross or repeated misbehavior, including but not limited to, abusive behavior to *HealthKeepers providers* and *HealthKeepers* administrative personnel in applying for or seeking any benefits under this *EOC,* then *HealthKeepers* may terminate *your* coverage upon 31 days written notice.

d. When, after reasonable efforts (including changing physicians), *you* cannot establish or maintain a satisfactory physician-patient relationship with *your PCP* ***HealthKeepers*** may terminate *your* coverage upon 31 days written notice. Evidence of an unsatisfactory physician-patient relationship may include *your* refusal to accept procedures or treatment recommended by *your PCP*. When a *HealthKeepers physician* regards such refusal as incompatible with the continuance of the physician-patient relationship and as obstructing the provision of proper medical care *HealthKeepers* may terminate *your* coverage and disclaim all financial responsibility for any further *covered service* costs incurred by *you*.

Termination for loss of eligibility

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

Termination for employer default

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

discontinuance. If payment is not made within the grace period *HealthKeepers* may cancel coverage as of the end of the grace period or 15 days from the date written notice of termination is provided by *HealthKeepers* to the employer, whichever is later.

Termination of the agreement

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

Reinstatement

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

Continuing coverage when eligibility ends

A *subscriber* and enrolled dependents may be eligible for coverage under an individual plan.

Important information about your coverage

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

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

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

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

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

Statement of ERISA rights

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

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

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

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

Plan "fiduciaries"

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called

"fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants.

- No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial.
- You have the right to have the plan administrator review and reconsider your claim.

Enforcement of ERISA rights

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

- If you request materials to which you are entitled 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.

Changes in your HealthKeepers

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

Notice in writing

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

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

Grievance/appeal and external review procedures

We want your experience with us to be as positive as possible. There may be times, however, when *you* have a complaint, problem, or question about *your* plan or a service *you* have received. In those cases, please contact Member Services by calling the number on the back of *your* ID card. *We* will try to resolve *your* complaint informally by talking to *your* provider or reviewing your claim. If *you* are not satisfied with the resolution of *your* complaint, *you* have the right to file an appeal, which is defined as follows:

Complaints typically involve issues such as dissatisfaction about services, quality of care, the choice of and accessibility to participating providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by *us*. 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 *HealthKeeper's* receipt of *your* complaint. If *HealthKeepers* is unable to resolve *your* complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve *your* complaint. *HealthKeepers* will then respond to *you* within an additional 30 calendar days. Written complaints may be filed to the following address:

HealthKeepers, Inc.
Attention: Grievances and Appeals
P.O. Box 26623
Richmond, VA 23261-6623

Grievance/appeal process

HealthKeepers 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. There are two types of appeals. 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.

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 *HealthKeepers* should consider when reviewing *your* appeal. Please include with the explanation:

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

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

For medical and prescription drug or pharmacy issues:
HealthKeepers, Inc.
Attention: Grievances and Appeals
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.

Prescription drug list exceptions
Please refer to the "Prescription drug list" section in "Prescription drug benefit at a retail or home delivery (Mail Order) pharmacy" for the process to submit an exception request for drugs not on the Prescription drug list.

How HealthKeepers will handle your appeal
In reviewing *your* appeal, *HealthKeepers* 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 resolve and respond in writing to *your* appeal within the following time frames:

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

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

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

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

External review

If the outcome of the appeal is adverse to *you, you* may be eligible for an independent external review pursuant to federal law.

You must submit *your* request for external review to *us* within four (4) months of the notice of *your* final adverse determination.

A request for external review must be in writing unless *we* determine that it is not reasonable to require a written statement. *You* do not have to re-send the information that *you* submitted as part of the internal appeal. However, *you* are encouraged to submit any additional information that *you* think is important for review.

For *pre-service claims* involving urgent/concurrent care, *you* may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through *our* internal appeal process. *You* or *your* authorized representative may request it orally or in writing. All necessary information, including *our* decision, can be sent between *us* and *you* by telephone, facsimile or other similar method. To proceed with an expedited external review, *you* or *your* authorized

representative must contact *us* at the number shown on *your* identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless *we* determine that it is not reasonable to require a written statement. Such requests should be submitted by *you* or *your* authorized representative to:

Address:

HealthKeepers, Inc.

Attention: Grievances and Appeals

P.O. Box 27401

Richmond, VA 23279

Telephone:

804-358-7390

in Richmond

800-421-1880

from outside Richmond

Your decision to seek external review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an appeal before filing a lawsuit

You must exhaust the plan's internal appeals procedure (but not an external review) before filing a lawsuit or taking other legal action of any kind against the plan. If *your* health benefit plan is sponsored by *your* employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and *your* appeal as described above results in an *adverse benefit determination, you* have a right to bring a civil action under Section 502(a) of ERISA.

The plan reserves the right to modify the policies, procedures and time frames in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Limitations of damages

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

Time limits on legal action

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

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

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

HealthKeeper's continuing rights

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

The HealthKeeper's relationship to providers

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

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

Special limitations

The rights of *members* and obligations of *HealthKeepers* are subject to the following special limitations: To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other *emergency* or similar event not within the control of *HealthKeepers* results in the facilities, personnel, or financial resources of *HealthKeepers* being unavailable to provide or arrange for the provision of *covered services,*

HealthKeepers shall make a good faith effort to provide or arrange for the provision of such health services taking into account the impact of the event. In such an event, *HealthKeepers* and *HealthKeepers providers* shall render covered hospital and medical services insofar as practical, and according to their best judgment. *HealthKeepers* and *HealthKeepers providers* shall incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.

Member rights and responsibilities

As a *member you* have rights and responsibilities when receiving health care. As *your* health care partner, *we* want to make sure *your* rights are respected while providing *your* health benefits. That means giving *you* access to *our* network health care *providers* and the information *you* need to make the best decisions for *your* health. As a *member*, *you* should also take an active role in *your* care.

You have the right to:

- Speak freely and privately with *your* health *providers* about all health care options and treatment needed for *your* condition no matter what the cost or whether it is covered under *your* plan.
- Work with *your* doctors to make choices about *your* health care.
- Be treated with respect and dignity.
- Expect us to keep *your* personal health information private by following *our* privacy policies and state and Federal laws.
- Get the information *you* need to help make sure *you* get the most from *your* health plan, and share *your* feedback. This includes information on:
    - *our* company and services.
    - *our* network of health care *providers*.
    - *your* rights and responsibilities.
    - the rules of *your* health plan.
    - the way *your* health plan works.
- Make a complaint or file an appeal about:
    - *your* health plan
    - any care *you* receive.
    - any *covered service* or benefit decision that *your* health plan makes.
- Say no to care, for any condition, sickness or disease, without having any effect on any care *you* may get in the future. This includes asking *your* doctor to tell *you* how that may affect *your* health now and in the future.
- Get the most up-to-date information from a health care *provider* about the cause of *your* illness, *your* treatment and what may result from it. *You* can ask for health if *you* do not understand this information.

You have the responsibility to:

- Read all information about *your* health benefits or ask for help if *you* have questions.
- Follow all health plan rules and policies.
- Choose an in-network primary care physician, also called a PCP, if *your* health care plan requires it.
- Treat all doctors, health care *providers* and staff with respect.
- Keep all scheduled appointments. Call *your* health care *provider's* office if *you* may be late or need to cancel.
- Understand *your* health problems as well as *you* can and work with *your* health care *providers* to make a treatment plan that *you* all agree on.

- Inform *your* health care *providers* if *you* don't understand any type of care you're getting or what they want *you* to do as part of *your* care plan.
- Follow the health care plan that *you* have agreed on with *your* health care *providers*.
- Give *us*, *your* doctors and other health care *providers* the information needed to help *you* get the best possible care and all the benefits *you* are eligible for under your health plan. This may include information about other health insurance benefits *you* have along with *your* coverage with *us*.
- Inform customer service if *you* have any changes to *your* name, address or family members covered under *your* plan.

If *you* would like more information, have comments or would like to contact *us*, please go to anthem.com and select customer support >contact us. Or call the member services number on *your* ID card.

We want to provide high quality benefits and customer service to *our members*. Benefits and coverage for services given under the plan are governed by the booklet and not by this member rights and responsibilities statement.

Definitions

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

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

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

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.

Brand name drug
prescription drugs that the PBM has classified as brand name drugs through use of an independent proprietary industry database.

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

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

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

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

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

Emergency

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

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

Evidence of Coverage ("EOC")

is the document that fully explains your health care benefits.

Experimental/investigative

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

Generic drugs

prescription drugs that the PMB has classified as generic drugs through use of an independent proprietary industry database. Generic drugs have the same active ingredients, must meet the same FDA rules for safety, purity, and potency, and must be given in the same form (tablet, capsule, cream) as the brand name drug.

Group administrator

is the benefits administrator at the subscriber's employer.

HealthKeepers physician

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

HealthKeepers provider

is a medical group, HealthKeepers physician, hospital, skilled nursing facility, pharmacy, or any other duly licensed institution or health professional who has contracted with HealthKeepers or its designee to provide covered services to members. This includes any provider that state law says we must cover (chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife, marriage and family therapist or licensed acupuncturist) when they give you services that state law says we must cover. A list of HealthKeepers providers is made available to each subscriber prior to enrollment. A current list may be obtained from HealthKeepers upon request and may be seen by visiting HealthKeeper's website page at www.anthem.com. The list shall be revised by HealthKeepers from time to time as HealthKeepers deems necessary.

HealthKeepers, we, us, our

refers to HealthKeepers, Inc.

High dose

is 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 home infusion services; which is therapy including such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Home infusion therapy does not require that the patient is confined to his/her home.

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

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

Maintenance medications
please see the "Prescription drug benefit at a retail or home delivery (mail order) pharmacy" section for details.

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

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

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

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

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

Member
is any subscriber or enrolled dependent.

Mental health and substance use disorder
is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use disorder condition.

Out-of-plan benefits

are benefits for care received from a HealthKeepers provider or services received from a non-HealthKeepers provider without a referral from your PCP.

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

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

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

Pharmacy
a place licensed by state law where you can get prescription drugs and other medicines from a licensed pharmacist when you have a prescription from your doctor.

Pharmacy and Therapeutics (P&T) Process
a process to make clinically based recommendations that will help you access quality, low cost medicines within your plan. The process includes health care professionals such as nurses, pharmacists, and doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Plan administrator
is your group administrator or the person selected by your employer to administer the provisions of the plan.

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-service claims
are claims for a service where the terms of the EOC require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive

authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.

Prescription drug (drug) (also referred to as legend drug)
is a medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when one or more ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer
- Insulin, diabetic supplies, and syringes.

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

Referral
is 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.

Service area
is the geographic area within which covered services from an in-plan provider. For the purposes of offering coverage and determining eligibility, the service area for HealthKeepers is all of Virginia, excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.

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

Specialty drugs
are drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

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

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

Telemedicine services
means the use of electronic technology or media, including interactive audio, or video, for the purpose of diagnosing or treating a patient or consulting with health care providers regarding a patient's diagnosis, or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire.

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

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

Visit
is a period during which a member meets with a provider to receive covered services. If during the course of one visit, multiple types of service are received where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.

You, your
any member.

Exhibit A

Experimental/Investigative Criteria

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

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

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

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

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

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

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

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

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

Clinical Trial Costs

Benefits include coverage for services such as patient care costs, given to you as a participant in an approved clinical trial if the services are *covered services* under this plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your plan may require *you* to use an in-network provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to *you* in connection with an approved clinical trial that would otherwise be covered by this plan.

When a requested service is part of an approved clinical trial, it is a *covered service* even though it might otherwise be investigational as defined by this plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our clinical coverage guidelines, related policies and procedures.

Your plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The investigational item, device, or service, itself; or
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

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End of Evidence of Coverage

Special features and programs

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

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

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

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

Health resources and tools

MyHealth@Anthem®

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

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

- Depression and Anxiety Screening – Answer general questions about depression and anxiety. Based on *your* responses, a nurse care manager may follow up with *you* to discuss treatment options and offer support.

Other tools and services

The following programs, tools and services are also included. 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.

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

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

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

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

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

Health guidance

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

24/7 NurseLine
Illness or injury can happen, no matter what time of day. As an *HealthKeepers member you* have access to a team of nurses, available to assist with *your* questions or concerns, 24 hours a day, seven days a week.

These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and *you* can call as often as *you* like. Call 800-382-9625.

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

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

Health management and coordination

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

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

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

We'll help *you* manage *your* symptoms related to pediatric and adult asthma, chronic obstructive pulmonary disease, pediatric and adult diabetes (Types I and II), heart failure, coronary artery disease, kidney disease, lower back pain, musculoskeletal pain and vascular at-risk conditions. 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.

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