Anthem. BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Evidence of Coverage

County of Prince George Virginia and Schools

POS Advantage One HSA

Take Control of Your Health

Your Health Care Plan

anthem.com

HealthKeepers, Inc. and Anthem Blue Cross and Blue Shield (trade name of Anthem Health Plans of Virginia, Inc.) Anthem POS AdvantageOne Lumenos Health Savings Account Plan 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.

Your employer has agreed to be subject to the terms and conditions of *HealthKeeper's* and *Anthem's provider* agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this plan.

This health plan is intended to be federally tax qualified and compatible with a qualified health savings account. The claims administrator does not provide tax advice. If *you* intent to purchase this plan to use with an HSA for tax purposes, *you* should consult with *your* tax advisor about whether *you* are eligible and whether *your* HSA meets all legal requirements.

Important phone numbers
Member Services
800-582-6941

How to obtain language assistance
We are committed to communicating with *our* members about their health plan, regardless of their language. *We* employ 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)
800-382-9625

Identity protection services

Identity protection services are available with *our Healthkeepers* and *Anthem* health plans. To learn more about these services, please visit www.anthem.com.

Key words

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

Anthem

Refers to Anthem Blue Cross and Blue Shield, the insurance company administering coverage for eligible subscribers/dependents living outside the HealthKeepers service area.

HealthKeepers

Refers to HealthKeepers, Inc., the health maintenance organization administering coverage for eligible subscribers/dependents living inside the HealthKeepers service area.

We, us, our

Refers to HealthKeepers and/or Anthem, unless specified elsewhere.

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 or Anthem, and for whom the premium required by the agreement has been paid to HealthKeepers or Anthem.

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 summary of any *deductibles, coinsurance,* and *copayments* that *you* must pay. Also listed are any plan year limits that apply. Please read the **What is covered** and prescription drug sections beginning on page 17 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 plan year maximums are calculated based upon the *maximum allowed amount*, not the provider's billed charges.

What will I pay?

The chart that follows shows the most *you* pay for plan year *deductibles* and annual *copayment* and *coinsurance* (if any) limits for *covered services* in one year of coverage. All covered benefits are subject to the *deductible* except for in-plan preventive care and routine eye exams.

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, amounts will accumulate for each family member until the "per family" amount is met, but no individual family member will contribute more than the "per member" amount shown.

The out-of-pocket limit generally includes all deductibles, copayments (if any) and coinsurance you pay during a plan 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	
Plan year deductible	$3000	$6000	$6000	$12000	
The most you will pay per plan year	$4000	$8000	$10000	$20000	

	In-plan		Out-of-plan	Detail
	Copayment	Coinsurance	Coinsurance	Page number

Summary of benefits continued

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

Summary of benefits continued

	In-plan Copayment	In-plan Coinsurance (after plan year deductible)	Out-of-plan Coinsurance (after plan year deductible)	Detail Page number
Ambulance travel (air and water) Out-of-plan providers may also bill you for any charges that exceed the plan's maximum allowed amount.	$0	0%	30%	17
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.	$0	0%	30%	17
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.				
Autism services				
Applied behavior analysis	$0	0%	30%	
All other services for autism	Copayment/coinsurance determined by service rendered			
Blood and administration of blood products	Copayment/coinsurance determined by service rendered			18
Clinical trials	Copayment/coinsurance determined by service rendered			18
Diabetic supplies, equipment, and education	Copayment/coinsurance determined by service rendered			19
Diagnostic tests and services For specific conditions or diseases at an emergency room or outpatient facility department.	$0	0%	30%	19
Dialysis treatments	$0	0%	30%	20
Doctor visits On an outpatient basis				20
Primary Care Physician	$0	0%	30%	
Specialty Care Providers	$0	0%	30%	
Online visits (other than mental health and substance use disorders)	$0	0%	30%	
Early intervention services Covered up to age 3	Copayment/coinsurance determined by service rendered			21
Emergency room visits	$0	0%	Covered at the in-plan benefit level	21
Important Note: Out-of-plan providers may also bill you for any charges over the maximum allowed amount.				
Home care services 100-visit plan year limit per member.	$0	0%	30%	22
Hospice care services	$0	0%	30%	22
Hospital services				23
Inpatient admission				
Facility services				

Summary of benefits continued

	In-plan		Out-of-plan	Detail
	Copayment	Coinsurance (after calender year deductible)	Coinsurance (after calendar year deductible)	Page number
Per stay	$0	0%	30%	
Professional provider services	$0	0%	30%	
Outpatient treatment				
Facility services	$0	0%	30%	
Professional provider services	$0	0%	30%	
Infusion services-outpatient services				24
Facility services	$0	0%	30%	
Professional provider services	$0	0%	30%	
Ambulatory infusion centers	$0	0%	30%	
Home services	$0	0%	30%	
Lymphedema	Copayment/coinsurance determined by service rendered			24
Maternity				24
Inpatient admission				
Facility services				
Per stay	$0	0%	30%	
Professional provider services	$0	0%	30%	
Prenatal, postnatal and delivery	$0	0%	30%	24
Diagnostic tests Maternity related, such as ultrasounds and fetal monitor procedures				24
Facility services	$0	0%	30%	
Professional provider services	$0	0%	30%	
Medical equipment (durable), devices, appliances, formulas, supplies and medications				
Medical equipment (durable), devices and appliances	$0	0%	30%	25
Medical formulas, supplies and medications	$0	0%	30%	25
Injectable medications Excludes allergy injections/serum	$0	0%	30%	26
Prosthetics	$0	0%	30%	26
Mental health and substance use disorder				26
Inpatient admission (including residential treatment centers)				
Facility services				
Per stay	$0	0%	30%	
Professional provider services	$0	0%	30%	
Partial day program	$0	0%	30%	
Outpatient treatment (including online visits)	$0	0%	30%	
Nutritional counseling For eating disorders	Copayment/coinsurance determined by service rendered			18

Summary of benefits continued

	In-plan		Out-of-plan	Detail
	Copayment	Coinsurance (after plan year deductible)	Coinsurance (after plan year deductible)	Page number
Preventive care services for children and adults	$0	0%	30%	27
The plan year deductible 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 plan 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 plan year deductible.				
Skilled nursing facility stays* 100-day per stay limit	$0	0%	30%	29
Spinal manipulation and manual medical therapy services * 30-visits plan year limit per member	$0	0%	30%	29
Surgery				29
Inpatient admission				
Facility services				
Per stay	$0	0%	30%	
Professional provider services	$0	0%	30%	
Outpatient treatment				
Facility services	$0	0%	30%	
Professional provider services	$0	0%	30%	
Therapy – outpatient services				
Chemotherapy, radiation, cardiac rehabilitation and respiratory				31
Facility services	$0	0%	30%	
Professional provider services	$0	0%	30%	
Physical, speech, and occupational * 60 combined visits per member per plan year for physical and occupational therapy; 60 visits per member per plan year for speech therapy. Limit does not apply to autism services.				31
Facility services	$0	0%	30%	
Professional provider services	$0	0%	30%	
Wigs Limited to one wig per member per plan year	$0	0%	30%	32

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

Summary of benefits continued

	Detail Page number
Prescription drug retail pharmacy and home delivery (mail order) benefits	32

All *prescription drug* expenses are subject to the plan year *deductible* shown on page 1. Once the plan year *deductible* has been satisfied, the following benefits apply.

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*.

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 Note: A 90-day supply is available at maintenance pharmacies. When you get a 90-day supply at a maintenance pharmacy, three (3) retail pharmacy copayments (one for each 30-day period) will apply. When you get a 30-day supply, one copayment per prescription order will apply.
Home delivery (mail order) pharmacy	90 days
Specialty pharmacy (in-network and out-of-network)	30 days* *See additional information in the “Specialty drug copayments / coinsurance” later in this section.
Prescription drug copayment / coinsurance for Preventive Rx prescription drugs as listed on the Expanded list	No copayment / deductible / coinsurance

Retail and specialty pharmacy copayments / coinsurance

	Copayment	Coinsurance
Tier 1 prescription drugs	$10	0%
Tier 2 prescription drugs	$30	0%
Tier 3 prescription drugs	$50	0%

Home delivery pharmacy copayments / coinsurance

	Copayment	Coinsurance
Tier 1 prescription drugs	$25	0%
Tier 2 prescription drugs	$75	0%

Summary of benefits continued

Tier 3 prescription drugs	$125	0%

Retail maintenance pharmacy copayments / coinsurance

	Copayment	Coinsurance
Tier 1 prescription drugs	$30	0%
Tier 2 prescription drugs	$90	0%
Tier 3 prescription drugs	$150	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 30-day supply at a retail *pharmacy*.

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

Note: *Prescription drugs* will always be dispensed as ordered by *your* doctor. *You* may ask for, or *your* doctor may order, the *brand name* drug. However, if a *generic drug* is available, *you* will have to pay the difference in cost between the *generic* and the *brand name drug*, as well as *your* tier 1 *copayment / coinsurance*. By law, *generic* and *brand name drugs* must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet give the same quality. For certain higher cost generic *drugs*, *we* reserve the right, in *our* sole discretion, to make an exception and not require *you* to pay the difference in cost between the *generic* and *brand name drug*.

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 and Anthem to carry out certain functions with respect to claims operation.

Carry your identification ("ID") card

Your ID card identifies *you* as a *member* and contains important health care coverage information. Eligible *subscribers* and their dependents living in the *HealthKeepers service area* will be enrolled in coverage offered by *HealthKeepers,* while eligible *subscribers* and their dependents living outside the *HealthKeepers* service area will be enrolled in coverage offered by *Anthem. Your* coverage ID card will clearly indicate the company through which *you* and *your* eligible dependents are enrolled.

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 are a *HealthKeepers* or *Anthem* member. *Participating providers* have agreed to submit claims to *us* on *your* behalf.

Primary care physicians and specialty care providers

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

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

When you need to access health care

You have the freedom to receive care from any *provider* or *facility*. However, *you* receive the highest level of benefits when *you* receive care from *participating providers* and *facilities*. *Members* enrolled with *HealthKeepers* receive the highest level of benefits from *providers* and *facilities* who have contracted to participate in the *HealthKeepers* network. *Members* enrolled with *Anthem* receive the highest level of benefits from *providers* and *facilities* who have contracted to participate in the *Anthem* network.

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

- Refer to the directory of network *providers* at www.anthem.com, which lists doctors and health care *facilities* that participate in the *HealthKeepers* or *Anthem* networks, as well as information about the standards of care in area *hospitals*.

- Call Member Services to request a list of doctors and health care *facilities* that participate in *your* health plan's network, based on specialty and geographic area.
- Check with your doctor or health care *facility*.
- Ask *your group administrator.*

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

If *you* have an emergency medical condition, go to the nearest appropriate *provider* or medical *facility*. *Medically necessary* screening and stabilization services will be covered whether *you* get care from an in-plan or *out-of-plan provider*. Treatment *you* get after *your* condition has stabilized is not emergency care. After *your* condition has been stabilized, if *you* continue to get care from an *out-of-plan provider*, *you* or *your physician* can call us to have the services authorized for the highest level of benefits.

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 Member 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.

Note: If *you* are unsure if *your* condition requires emergency or urgent care, the 24/7 NurseLine is available to assist *you* 7 days a week. Call the 24/7 NurseLine at 800-382-9625.

Non-participating providers

In the event that *you* receive *covered services* from a non-*participating provider,* then *we* reserve the right to make payment of such *covered services* directly to *you,* the non-*participating provider,* or any other person responsible for paying the non-*participating 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-*participating provider.* If *you* receive services from a non-*participating 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.

Continuity of care

If *your* in-plan *provider* leaves *our* network for any reason other than termination for cause, and *you* are in an active course of treatment, *you* may be able to continue seeing that *provider* for a limited period of time

and still get in-plan benefits. "Active course of treatment" for any course of medically necessary continuing care includes, but is not limited to:

- An ongoing course of treatment for a life-threatening condition,
- An ongoing course of treatment for a serious acute condition (examples include chemotherapy, radiation therapy and post-operative visits),
- The second or third trimester of pregnancy and through the postpartum period for that delivery,
- *Members* who are terminally ill as defined by the Social Security Act, or
- An ongoing course of treatment for a health condition for which the *physician* or health care *provider* attests that discontinuing care by the current *physician* or *provider* would worsen *your* condition or interfere with anticipated outcomes.

An "active course of treatment" includes treatments for mental health and substance use disorders.

For *members* who are terminally ill, coverage is extended for the remainder of the person's life for the direct care of the terminal illness. For *members* who are in the second or third trimester of pregnancy, coverage is extended through the postpartum care for that delivery. In all other circumstances, *you* may be able to continue seeing that *provider* for 90 days. If *you* wish to continue seeing the same *provider*, *you* or *your* doctor should contact Member Services for details.

In the absence of proper authorization for coverage at the in-plan level, *you* may choose to receive services on an *out-of-plan* basis.

The BlueCard® Program

Like all Blue Cross & Blue Shield plans through the country, *we* participate in a program called "BlueCard," which provides services to *you* when *you* are outside *our service area*. For more details on this program, please see "Inter-Plan Arrangements" in the **Claims and payments** section.

Getting approval for benefits

Your plan includes the process of *utilization review* to decide when services are *medically necessary* or *experimental/investigational* as those terms are defined in this *EOC*. *Utilization review* aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Certain services must be reviewed to determine *medical necessity* in order for *you* to get benefits. *Utilization review* criteria will be based on many sources including coverage and clinical guidelines. *HealthKeepers* and *Anthem* may decide that a service that was asked for is not *medically necessary* if *you* have not tried other treatments that are more cost effective.

If *you* have any questions about the information in this section, *you* may call the Member Services phone number on the back of *your* Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if *we* decide *your* services are *medically necessary*. For benefits to be covered, on the date *you* get service:

1. *you* must be eligible for benefits;
2. premium must be paid for the time period that services are given;
3. the service or supply must be a *covered service* under *your* plan;

4. the service cannot be subject to an exclusion under *your* plan; and
5. *you* must not have exceeded any applicable limits under *your* plan.

Types of reviews

- **Pre-service review –** A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.
    - **Precertification –** A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for *you* to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of *medical necessity* or is *experimental / investigational* as those terms are defined in this *EOC*. For admissions following *emergency care*, *you*, *your* authorized representative or doctor must tell *us* within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Childbirth admissions continuing beyond 48/96 hours from delivery require precertification. Continued Stay admissions occur when there is a problem and/or the mother and baby are not sent home at the same time.

- **Continued stay / Concurrent review** - A *utilization review* of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating *provider* or any *doctor* with knowledge of *your* medical condition, without such care or treatment, *your* life or health or *your* ability to regain maximum function could be seriously threatened or *you* could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which *we* have a related clinical coverage guideline and are typically initiated by *us*.

Who is responsible for precertification?

Typically, in-plan *providers* know which services need precertification and will get any precertification when needed. *Your primary care physician* and other in-plan *providers* have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering *provider*, *facility* or attending doctor (“requesting *provider*”) will get in touch with *us* to ask for a *precertification*. However, *you* may request a precertification or *you* may choose an authorized representative to act on *your* behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider network status	Responsibility to get precertification	Comments
In plan	Provider	The *provider* must get precertification when required
Out of plan/ non-participating	Member	*Member* must get precertification when required. (Call Member Services.) *Member* may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be *medically necessary*.
Blue Card provider	Member (Except for *inpatient* admissions)	*Member* must get precertification when required. (Call Member Services.) *Member* may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be *medically necessary*. Blue Card *providers* must obtain precertification for all *inpatient* admissions.
NOTE: For an *emergency care* admission, precertification is not required. However, *you*, *your* authorized representative or doctor must tell *us* within 48 hours of the admission or as soon as possible within a reasonable period of time.		

How decisions are made

We use *our* clinical coverage guidelines and other applicable policies and procedures to help make *our medical necessity* decisions. This includes decisions about *prescription drugs* as detailed in the section **Prescription drugs administered by a medical provider**. Coverage and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. *We* reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning *your* request. To ask for this information, call the precertification phone number on the back of *your* identification card.

If *you* are not satisfied with *our* decision under this section of *your* benefits, please refer to the "Grievance/Appeals and External Review Procedures" section to see what rights may be available to *you*.

Type of review	Timeframe requirement for decision and notification
Urgent pre-service review	72 hours from the receipt of request
Non-urgent pre-service review	15 calendar days from the receipt of the request
Urgent concurrent / Continued stay review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request

Type of review	Timeframe requirement for decision and notification
Urgent Concurrent / Continued stay review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Concurrent / Continued stay review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service review	30 calendar days from the receipt of the request

If more information is needed to make *our* decision, *we* will tell the requesting *provider* of the specific information needed to finish the review. If *we* do not get the specific information *we* need by the required timeframe, *we* will make a decision based upon the information *we* have.

We will notify *you* and *your provider* of *our* decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important information

We may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in *our* sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying *providers* to take part in a program or *provider* arrangement 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 *we* exempt a process, *provider* or claim from the standards which otherwise would apply, it does not mean that *we* will do so in the future, or will do so in the future for any other *provider*, claim or *member*. *We* may stop or change any such exemption with or without advance notice.

You may find out whether a *provider* is taking part in certain programs or *provider* arrangement by checking *your* on-line *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*.

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 you and *HealthKeepers* or *Anthem,* and *you* or *your* authorized representative agree to the alternate or extended benefit in writing. 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 *we* may offer a *member* and/or their *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 a different means. *You* may contact *us* at the Member Services 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.)

Crediting prior plan coverage

If *you* were covered by the group's prior carrier / plan immediately before the group signs up with *us*, with no break in coverage, then *you* will get credit for any accrued *deductible* and, if applicable and approved by *us*, out-of-pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the group's coverage with *us* began, or to people who join the group later.

If *your* group moves from one of *our* plans to another, (for example, changes its coverage from HMO to PPO), and *you* were covered by the other product immediately before enrolling in this product with no break in coverage, then *you* may get credit for any accrued *deductible* and out-of-pocket amounts, if applicable and approved by *us*. Any maximums, when applicable, will be carried over and charged against the maximums under this plan.

If *your* group offers more than one of *our* products, and *you* change from one product to another with no break in coverage, *you* may get credit for any accrued *deductible* and, if applicable, out-of-pocket amounts and any maximums will be carried over and charged against maximums under this plan.

If *your* group offers coverage through other products or carriers in addition to *ours*, and *you* change products or carries to enroll in this product with no break in coverage, *you* may get credit for any accrued *deductible*, out-of-pocket, and any maximums under this plan.

This section does not apply to you if:

- *Your* group moves to this plan at the beginning of a benefit period;
- *You* change from one of our individual policies to a group plan;
- *You* change employers; or

- *You* are a new *member* of the group who joins the group after the group's initial enrollment with *us*.

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 or Anthem. If a service is not considered *medically necessary*, *you* will be responsible for the charges. Additionally, *we* will only pay the charges incurred by *you* when *you* are actually eligible for the *covered services* received (for example, the premium has been paid by *you* or on *your* behalf).

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

Ambulance travel

Medically necessary ambulance services 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-plan *hospital* to an in-plan *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-plan *hospital* to an in-plan *hospital*
  Between a *hospital* and an approved *facility*.

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

Non-emergency ambulance services are subject to *medical necessity* reviews by *us*. When using an air ambulance for non-emergency transportation, *we* reserve the right to select the air ambulance *provider*. If *you* do not use the air ambulance *provider we* select, the out-of-plan *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*.

Blood and administration of blood products

Your coverage includes benefits for blood and the administration of blood products for the treatment of hemophilia and congenital bleeding disorders.

Clinical trial costs

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

Dental services (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: *We* provide coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by *us,* are not *covered services.*

Diabetic supplies, equipment, and education

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

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

Covered services include:

Office visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury. Benefits also include *visits* for shots needed for treatment (for example, allergy shots).

Home visits for medical care to examine, diagnose, and treat an illness or injury. Please note that doctor visits in the home are different than the “Home Care Services” benefit described earlier in this booklet.

Retail health clinic care for limited basic health care services to *members* on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by physician’s assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-in doctor’s office for services limited to routine care and treatment of common illnesses for adults and children. *You* do not have to be an existing patient or have an appointment to use a walk-in doctor’s office.

Urgent care when an urgent rather than an *emergency* health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an emergency room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Online visits when available in your area. *Covered services* include a medical visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or doctor to doctor discussions. For *mental health and substance use disorder* online visits, see the “Mental health and substance use disorder services” section.

Interactive *telemedicine services*

Professional medical visits to an ambulatory surgery center, emergency room or *hospital outpatient* department.

Prescription drugs administered in the office

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

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

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 or behavioral health 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 or the health of another person 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 or behavioral health 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 or behavioral health 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."

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:

1. The amount negotiated with in-plan providers for the emergency service;
2. 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
3. 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 "Getting approval for benefits" 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*, *covered services* will be covered at the *out-of-plan* level unless *we* agree to cover them as an authorized service.

Home care services

When authorized, *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

The services and supplies listed below are *covered services* when given by a hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. *Covered services* include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term *inpatient hospital* care when needed in periods of crisis or as respite care. Coverage includes short-term *inpatient* care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute *inpatient* care for

the covered person in order to provide the covered person's primary caregiver a temporary break from caregiving responsibilities.

- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the member's death.
- Bereavement services are available to surviving members of the immediate family for one year after the member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your doctor and hospice medical director must certify that *you* are terminally ill and likely have less than six months to live. *Your* doctor must agree to care by the hospice and must be consulted in the development of the care plan. The hospice must keep a written care plan on file and give it to *us* upon request.

Benefits for *covered services* beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a member in hospice. These additional *covered services* will be covered under other parts of this plan.

Hospital services

Your coverage provides benefits for the *hospital* and doctors' services when you are treated on an *outpatient* basis, or when *you* are an *inpatient* because of illness, injury, or pregnancy. (See **Maternity** 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 *participating physicians*.

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

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

Maternity

Prenatal and newborn care

If the *subscriber* or *subscriber's* dependent becomes pregnant, *we* provide 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 interruption of pregnancy;
- use of the delivery room and care for normal deliveries; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

Important note about maternity admissions: Under federal law, *we* may not limit benefits for any *hospital* length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, *we* may

not require a *provider* to get authorization from *us* before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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 participating *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 *participating 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 participating 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.
- **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 *physician* weekly or more often,
  - Rehabilitation, therapy, and education.
- **Outpatient services** including office *visits*, therapy and treatment, partial hospitalization/day treatment 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*).
- **Online visits** when available in *your* area. *Covered services* include a medical visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or doctor to doctor discussions.

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 impose 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 *participating physician* for the care of or related to the female reproductive system and breasts. The obstetrician-gynecologist must obtain authorization from us for *inpatient hospital* services and *outpatient* surgery.

Preventive care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no *deductible*, *copayments*, or *coinsurance* when *you* use an in-plan *provider*.

Certain benefits for *members* who have current symptoms or a diagnosed health problem may be covered under the “Diagnostic Tests” benefit, instead of this benefit, if this coverage does not fall within the state or ACA-recommended preventive services.

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 benefit when *medically necessary* according to *your* attending *provider,* 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

- 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 800-582-6941 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.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 *participating provider* skilled nursing *facility* or in a skilled nursing bed in a *participating 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. *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 services

Your coverage includes spinal manipulation and manual medical therapy services. *Covered services* include examination, re-examination, manipulation, conjunctive therapy, radiology, durable medical equipment, and laboratory tests related to the delivery of these services.

Surgery

General surgery
Your coverage includes benefits for surgery services when approved in advance by *us* 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.

Important note about hysterectomy admissions: *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.
Oral surgery

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.

Important note about mastectomy admissions: *Hospital* admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. *Hospital* admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours.

Sterilization services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the Preventive care benefit:

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 *our* judgment, 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. It does not include massage therapy services at spas or health clubs.

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.

Wigs

Your coverage includes benefits for a wig when needed to replace scalp hair following an illness or injury. Benefits are limited to one wig per *member* per plan year maximum shown on the **Summary of benefits**, and are available despite the exclusion in the plan of benefits for, or related to, cosmetic surgery or procedures.

Prescription drugs administered by a medical provider

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

Benefits for *drugs* that *you* inject or get through *your pharmacy benefits* (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" section that follows.

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 eligible for coverage. In order to determine if the *prescription drug* is eligible for coverage, *we* have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result, requirements, and/or presence of a specific condition or disease,
- Specific *provider* qualifications including, but not limited to REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one *drug* or a *drug* regimen or another treatment be used prior to use of another *drug* or a *drug* regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another,
- Use of an Anthem Prescription Drug List (a formulary developed by *us*) which is a list of FDA-approved *drugs* that have been reviewed and recommended for use based on their quality and cost effectiveness.

Precertification

Precertification may be required for certain *prescription drugs* to make sure proper use and guidelines for *prescription drug* coverage are followed. *We* will give the results of *our* decision to both *you* and *your provider*.

For a list of *drugs* that need precertification, 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 prescription *drug* or related item on the list does not guarantee coverage under *your* plan. *Your provider* may check with *us* to verify prescription *drug* coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

Designated pharmacy provider

HealthKeepers and *Anthem* in their sole discretion, may establish one or more *designated pharmacy provider* programs which provide specific *pharmacy* services (including shipment of *prescription drugs*) to *members*. An in-plan *provider* is not necessarily a *designated pharmacy provider*. To be a *designated pharmacy provider*, the in-plan *provider* must have signed a *designated pharmacy provider* agreement with *us*. *You* or *your provider* can contact Member Services to learn which *pharmacy* or *pharmacies* are part of the *designated pharmacy provider* program.

For *prescription drugs* that are shipped to *you* or *your provider* and administered in *your provider's* office, *you* and *your provider* are required to order from a *designated pharmacy provider*. A patient care coordinator will work with *you* and *your provider* to obtain precertification and to assist shipment to *your provider's* office.

We may also require *you* to use a *designated pharmacy provider* to obtain *prescription drugs* for treatment of certain clinical conditions such as hemophilia. *We* reserve *our* right to modify the list of *prescription drugs* as well as the setting and/or level of care in which the care is provided to *you*. *HealthKeepers* and *Anthem* may, from time to time, change with or without advance notice, the *designated pharmacy provider* for a drug, if in *our* discretion, such change can help provide cost effective, value based and/or quality services.

If *you* are required to use a *designated pharmacy provider* and *you* choose not to obtain *your prescription drug* from a *designated pharmacy provider*, coverage will be provided at the out-of-network level.

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

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*. 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* by a medical *provider* in a medical setting (e.g., doctor's office *visit*, 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
Prescription drug benefits may require prior authorization to determine if *your* drugs should be covered. *Your* in-network pharmacist will be told if prior authorization is required and if any additional details are needed for *us* to decide benefits.

Prior authorization
Prescribing *providers* must obtain prior authorization in order for *you* to get benefits for certain drugs. At times *your provider* will initiate a prior authorization on *your* behalf before *your* pharmacy fills *your* prescription. At other times, the pharmacy may make *you* or *your provider* aware that a prior authorization or other information is needed. In order to determine if the *prescription drug* is eligible for coverage, *we* have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:
- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result, requirements, and/or presence of a specific condition or disease,
- Specific *provider* qualifications including, but not limited to REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one *drug* or a *drug* regimen or another treatment be used prior to use of another *drug* or a *drug* regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another,
- Use of an Anthem Prescription Drug List (as described below).

You or *your provider* can get the list of the *drugs* that require prior authorization by calling Member Services at the phone number on the back of *your* identification card or check *our* website at www.anthem.com.

The list will be reviewed and updated from time to time. Including a *prescription drug* or related item on the list does not guarantee coverage under *your* plan. *Your provider* may check with *us* to verify *prescription drug* coverage, to find out which *drugs* are covered under this section and if any *drug* edits apply.

We may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in *our* sole discretion, such change furthers the provision of cost effective, value based and/or quality services

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

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 (including administration) 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.

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.

Maintenance pharmacy
You may also obtain a 90-day supply of covered *maintenance medications* from a *maintenance pharmacy*. 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.

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 and external review procedures" section of this *EOC*.

Specialty pharmacy

If *you* need a *specialty drug*, *you* or *your* doctor should order it from the PBM'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. *We* may require *you* or *your* doctor to order certain *specialty drugs* from the PBM's specialty *pharmacy*.

When *you* use the PBM's specialty *pharmacy,* its patient care coordinator will work with *you* and *your* doctor to get prior authorization and to ship *your specialty drugs* to *your* home or *your* preferred address. *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.

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 based 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*, *biosimilars, interchangeable biologic products,* or multi-source *brand drugs*.
- 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 *brand drugs, biosimilars, interchangeable biologic products*, or multi-source *brand drugs*.
- 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 *brand drugs, biosimilars, interchangeable biologic products*, or multi-source *brand drugs*.

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., 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.

We will act upon such requests within one business day of the receipt of the request.

PreventiveRx benefit

Note: The PreventiveRx benefit covers *prescription drugs* in addition to those required by federal law under the "Preventive care" benefit. Any *prescription drugs* covered under the "Preventive care" benefit will not be subject to *copayments*, *deductibles*, or *coinsurance* when *you* use an in-network *provider*.

Your plan includes the PreventiveRx benefit. This benefit waives *copayments*, *coinsurance*, and *deductible* amounts (if any) on *prescription drugs* listed in the PreventiveRx Expanded list. These *drugs* have been found useful in preventing disease or illness. *You* can get a copy of this list at www.anthem.com. The list will be reviewed and updated from time to time.

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.

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*. For questions or issues about therapeutic *drug* substitutes, call Member Services at the phone 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 the 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 those selected services that require **authorization in advance** as set forth in this *EOC*, when advance authorization is not obtained**.**

Your coverage does not include benefits for **applied behavioral treatment** (including, but not limited to, *applied behavior analysis* and intensive behavior interventions) for all indications except as described under "Autism services" in the **What is covered** section unless otherwise required by law.

B

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

C

Your coverage does not include benefits for certain *prescription drugs* if *you* could use a **clinically equivalent** *drug*, unless required by law. "Clinically equivalent" means *drugs* that for most members, will give *you* similar results for a disease or condition. If *you* have questions about whether a certain *drug* is covered and which *drugs* fall into this group, please call the number on the back of *your* identification card, or visit *our* website at www.anthem.com. If *you* or *your* doctor believes *you* need to use a different prescription drug, please have *your* doctor or pharmacist get in touch with *us*. *We* will cover the other *prescription drug* only if *we* agree that it is *medically necessary* and appropriate over the clinically equivalent drug. *We* will review benefits for the *prescription drug* from time to time to make sure the drug is still *medically necessary***.**

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*. *We* will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for **delivery charges** for the delivery of *prescription drugs*.

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;
- 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*.

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

Your coverage does not include **drugs** administered by a medical *provider* in the following circumstances:

- *drugs* in quantities which are over the limits set by the plan, or which are over any age limits set by *us*;
- *drugs* in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order;
- *drugs* prescribed by a *provider* that does not have the necessary qualifications, including certifications, as determined by *HealthKeepers* and *Anthem*;
- *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.

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

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

- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;
- subluxations of the foot;
- corns (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except as treatment for patients with diabetes or vascular disease);
- care of toenails (except as treatment for patients with diabetes or vascular disease);
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

G

Your coverage does not include **gene therapy** as well as any *drugs*, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

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 us.

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.*

L

Your coverage does not include refills of **lost or stolen drugs.**

M

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

- items that have both a non-therapeutic and therapeutic use, including but 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; and changes made to a home or place of business;
- replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft;
- surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury;
- non-*medically necessary* enhancements to standard equipment and devices; and
- supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is *medically necessary* in *your* situation. Reimbursement will be based on the *maximum allowed amount* for a standard item that is a *covered service*, serves the same purpose, and is *medically necessary*. Any expense that exceeds the *maximum allowed amount* for the standard item which is a *covered service* is your responsibility.

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 us at *our* 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 *us* to be not *medically necessary* if such services are received from a professional *provider* who does not control whether *you* are treated on an *inpatient* basis or as an *outpatient*, such as a pathologist, radiologist, anesthesiologist or consulting *physician*. Additionally, this exclusion shall not apply to *inpatient* services rendered by *your* admitting or attending *physician* other than *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 *our* decision that a service is *not medically necessary*.

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 **off label use**, unless *we* must cover it by law or *we* approve it. 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

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 **residential accommodations** to treat medical or behavioral health conditions, except when provided in a *hospital*, hospice, skilled nursing facility, or residential treatment center.

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

S

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

- not listed as covered under this *EOC*;
- not prescribed, performed, or directed by a provider licensed to do so;
- received from *providers* not licensed by law to provide *covered services* defined in this *EOC*. Examples include masseurs or masseuses (massage therapists), physical therapy 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, *we* 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 or supplies to treat **sexual dysfunction** (male or female sexual problems). This includes medical and mental health services.

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

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

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

Your coverage does not include benefits for **spinal manipulation** and manual medical interventions for an illness or injury other than musculoskeletal conditions.

T

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.

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.

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:

- For *members* through age 18, no benefit for frames or contact lenses purchased outside of the *Anthem* formulary;
- 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 terms 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.
- **Contraceptives** Contraceptive *drugs*, injectable contraceptive *drugs* and patches unless *we* must cover them by law.
- **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 the 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 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.
- **Drugs prescribed by providers lacking qualifications/certifications** *Prescription drugs* prescribed by a *provider* that does not have the necessary qualifications and including certifications as determined by *Healthkeepers* and *Anthem*.
- **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.
- **Gene therapy** Gene therapy as well as any *drugs*, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- **Infertility drugs** *Drugs* used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- **Items covered as durable medical equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the "Prescription 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** Off label use, unless *we* must cover the use by law, or if *we*, or the PBM, approve it. 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 permitted to be dispensed without a prescription and available over the counter. This exclusion does not apply to over-the-counter products that *we* must cover as a preventive care benefit under federal law with a prescription.
- **Sexual dysfunction drugs** *Drugs* 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*.

Plan year deductible

Your benefits include an *in-plan* and *out-of-plan* plan year *deductible* for certain *covered services.* Before *we* will make payments for *covered services* received *in-plan* or *out-of-plan, you* must first satisfy the *deductible.* The *in-plan deductible* is separate from the *out-of-plan deductible* and they do not accumulate towards each other. See the **Summary of benefits** section of this *EOC* for the amount of *your* plan year *deductible* and applicable services.

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.

Annual limit

Plan year limit

The **Summary of benefits** lists the *in-plan* and *out-of-plan* plan year limits for *copayments, coinsurance* or *deductible* (if any). The *in-plan* and *out-of-plan* plan year limits are separate and amounts applied to one do not apply to the other. If a *member* reaches the *in-plan* plan 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 plan year. If a *member* reaches the *out-of-plan* plan 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 plan year. When *a member* enrolled with *HealthKeepers* reaches the *in-plan* or *out-of-plan* plan year limit, they will be notified by us within 30 days.

The *copayments, coinsurance* and *deductible* (if any) for the services listed below are not counted toward the plan year limit and are never waived. Any *copayments, coinsurance* or *deductible* (if any) paid in excess of the plan 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;
- *deductible* amounts carried forward from the prior plan year;
- amounts above *maximum allowed amount.*

How we pay 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, *our* right to direct future payments to *you* or any other individual or facility. Notwithstanding any provision in this *EOC* to the contrary, however, *we:*

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

Maximum Allowed Amount

General

This section describes how *we* determine the amount of reimbursement for *covered services*. Reimbursement for services rendered by *participating providers* and non-*participating* providers is based on the plan's *maximum allowed amount* for the *covered service* that *you* receive. Please see "Inter-Plan Arrangements" later in this section for additional information.

The *maximum allowed amount* for this plan is the maximum amount of reimbursement we 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 *participating provider* or a non-*participating provider.* A *participating provider* is a provider who is in the *HealthKeepers* or *Anthem* network. For *covered services* performed by a *participating 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 *participating 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 *participating provider* or look on www.anthem.com.

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

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

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.

Providers who are not contracted for this product, but are contracted for other products with *us* are also considered *out-of-plan*. For this *EOC*, the *maximum allowed amount* for services from these *providers* will be one of the five methods shown above unless the contract between us and that *provider* specifies a different amount.

For *covered services* rendered outside *HealthKeepers* or *Anthem's service area* by *out-of-plan providers*, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the *maximum allowed amount* for out of area claims may be based on billed charges, the pricing *we* would use if the

healthcare services had been obtained within the *HealthKeepers* or *Anthem's service area*, or a special negotiated price.

Unlike *participating providers,* non-*participating 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 *participating 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.

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

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 *EOC* 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.

We 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 amount. When calculating these amounts, the charges for non-*covered services* are subtracted from the per diem amount.

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

The following are examples for illustrative purposes only; the amounts shown may be different than this booklet's cost share amounts; see your "Summary of benefits" for your applicable amounts.

Example: *Your* plan has a *coinsurance* cost share of 20% for in-plan services, and 30% for *out-of-plan* services after the in-plan or *out-of-plan deductible* has been met.

You undergo a surgical procedure in an in-plan *hospital*. The *hospital* has contracted with an *out-of-plan* anesthesiologist to perform the anesthesiology services for the surgery. *You* have no control over the anesthesiologist used.

- The *out-of-plan* anesthesiologist's charge for the service is $1200. The *maximum allowed amount* for the anesthesiology service is $950; *your coinsurance* responsibility is 20% of $950, or $190 and the remaining allowance from *us* is 80% of $950, or $760. *You* may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the *deductible* has been met, *your* total out of pocket responsibility would be $190 (20% *coinsurance* responsibility) plus an additional $250, for a total of $440.
- *You* choose an in-plan surgeon. The charge was $2500. The *maximum allowed amount* for the surgery is $1500; your *coinsurance* responsibility when an in-plan surgeon is used is 20% of $1500, or $300. *We* allow 80% of $1500, or $1200. The in-plan surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. *Your* total out-of-pocket responsibility would be $300.
- *You* choose an *out-of-plan* surgeon. The *out-of-plan* surgeon's charge for the service is $2500. The *maximum allowed amount* for the surgery service is $1500; *your coinsurance* responsibility for the *OUT-OF-PLAN* surgeon is 30% of $1500, or $450 after the *OUT-OF-PLAN deductible* has been met. *We* allow the remaining 70% of $1500, or $1050. **In addition**, the *out-of-plan* surgeon could bill *you* the difference between $2500 and $1500, so *your* total out-of-pocket charge would be $450 plus an additional $1000, for a total of **$1450**.

Authorized services

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

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Summary of benefits" for your applicable amounts.

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

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

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

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

Payment innovations program

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 network *providers* to *us* under the program(s).

Care coordination

We pay in-plan *providers* in various ways to provide *covered services* to *you*. For example, sometimes *we* may pay in-plan *providers* a separate amount for each *covered service* they provide. *We* may also pay them one amount for all *covered services* related to treatment of a medical condition. Other times, *we* may pay a periodic, fixed pre-determined amount to cover the costs of *covered services*. In addition, *we* may pay in-plan *providers* financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate in-plan *providers* for coordination of *member* care. In some instances, in-plan *providers* may be required to make payment to *us* because they did not meet certain standards. *You* do not share in any payments made by in-plan *providers* to us under these programs.

Program incentives

We may offer incentives from time to time, at *our* discretion, in order to introduce *you* to covered programs and services available under this plan. The purpose of these incentives include, but is not limited to, making *you* aware of cost effective benefit options or services, helping *you* achieve *your* best health, and encouraging *you* to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or *member* cost shares. Acceptance of these incentives is voluntary as long as *HealthKeepers* or *Anthem* offers the incentives program. *We* may discontinue an incentive for a particular covered program or service at any time. If *you* have any questions about whether receipt of an incentive or retailer coupon results in taxable income to *you*, *we* recommend that *you* consult *your* tax advisor.

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-*participating provider*.

Inter-Plan Arrangements

Out-of-area services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever *you* access healthcare services outside the geographic area *we* serve (the "*HealthKeepers* or *Anthem service area*"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When *you* receive care outside of the*HealthKeepers* or *Anthem service area*, *you* will receive it from one of two kinds of *providers*. Most *providers* ("*participating providers*") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some *providers* ("nonparticipating providers") don't contract with the Host Blue. *We* explain below how *we* pay both kinds of *providers*.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are *prescription drugs* that you obtain from a *pharmacy* and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when *you* receive *covered services* within the geographic area served by a Host Blue, *we* will still fulfill *our* contractual obligations. But, the Host Blue is responsible for: (a) contracting with its *providers*; and (b) handling its interactions with those Providers.

When you receive *covered services* outside the *HealthKeepers* or *Anthem service area*, and the claim is processed through the BlueCard Program, the amount *you* pay is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the *provider*. Sometimes, it is an estimated price that takes into account special arrangements with that *provider*. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of *providers*. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price *we* used for *your* claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements
With respect to one or more Host Blues, instead of using the BlueCard Program, *HealthKeepers* or *Anthem* may process your claims for *covered services* through Negotiated Arrangements for National Accounts.

The amount *you* pay for *covered services* under this arrangement will be calculated based on the lower of either billed charges for *covered services* or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to *HealthKeepers* or *Anthem* by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program
If *you* receive *covered services* under a Value-Based Program inside a Host Blue's *service area*, *you* will not be responsible for paying any of the *provider* incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to *HealthKeepers* or *Anthem* through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If *HealthKeepers* or *Anthem* has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the plan on your behalf, *HealthKeepers* or *Anthem* will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, *we* will include any such surcharge, tax or other fee as part of the claim charge passed on to *you*.

E. Nonparticipating Providers Outside Our Service Area

1. The pricing method used for nonparticipating *provider* claims incurred outside the *HealthKeepers* or *Anthem service area* is described in **Claims and payments**).

F. BlueCard Worldwide® Program
If *you* plan to travel outside the United States, call Member Services to find out *your* BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with *you*.

When *you* are traveling abroad and need medical care, *you* can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or *you* can call them collect at 804-673-1177.

Keep in mind, if *you* need Emergency medical care, go to the nearest *hospital*. There is no need to call before *you* receive care.

Please refer to the **How your coverage works** section in this *EOC* for further information. *You* can learn how to get preauthorization when *you* need to be admitted to the *hospital* for *emergency* or non-*emergency* care.

How Claims are Paid with BlueCard Worldwide
In most cases, when *you* arrange inpatient *hospital* care with BlueCard Worldwide, claims will be filed for *you*. The only amounts that *you* may need to pay up front are any *copayment*, *coinsurance* or *deductible* amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- *Inpatient hospital* care not arranged through BlueCard Worldwide; and
- *Outpatient* services.

You will need to file a claim form for any payments made up front.

When *you* need BlueCard Worldwide claim forms *you* can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

You will find the address for mailing the claim on the form.

When you must file a claim

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

In most cases, *we* will reimburse *you* for *covered services* paid for by *you* only if a completed claim (including receipt) has been received by *us* 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 800-582-6941 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

Anthem Blue Cross and Blue Shield
Attention: Operations
2015 Staples Mill Road
P.O. Box 27401
Richmond, VA 23279

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, *we* may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the **"When you must file a claim"** paragraph of this section will be processed within 30 days of receipt of the claim. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond 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, *we* will make *our* decision within 2 working days of its receipt of the medical information needed to process the claim.

We may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by *you* or *your* provider furnishing the additional information. *You* or *your* provider must submit the additional information to *us* within either 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 *us, 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 *our* appeal procedures and applicable time limits; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist *you* with the internal or external appeals process.

If all or part of a claim was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *we* 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.

Right of recovery and adjustment

Whenever payment has been made in error, *we* will have the right to recover such payment from *you* or, if applicable, the *provider* or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with *provider* and vendor contracts. *We* may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a *provider* or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, *we* have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. *We* will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

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 health maintenance organization 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.

If *you* are enrolled in a qualified high *deductible* health plan for purposes of the Health Savings Account provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and Section 223 of the Internal Revenue Code, any other coverage *you* have must also satisfy the requirements for qualified high *deductible* health plans, so as not to affect your tax status. In the event of coverage under more than one health plan, please seek the counsel of a tax advisor.

Calculation of the amount that would have been payable does not include the amount that is subject to the primary high-deductible health plan's *deductible*, if we have been advised by *you* that all plans covering *you* are high-deductible health plans and *you* intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

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 *ours,* 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 *we* provide secondary coverage, *we* first calculate the amount that would have been payable had *we* been primary. Then *we* coordinate benefits so that the combination of the primary plan's payment and *our* payment does not exceed the amount *we* 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.

If payments should have been made under this plan under the rules of this provision, but they have been made under any other coverage, *we* may pay an entity (*provider,* other carrier, etc.) that has paid any amounts *we* determine will meet the intent of this provision. These amounts shall be deemed to be benefits paid by *us* under your coverage. Upon this payment, *we* will no longer be liable under this plan.

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 *we* 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 *we* would have paid if it had been primary.

Overpayment of benefits

If *we* overpay benefits because of COB, *we* have the right to recover the excess from:

- any person to, or for whom such payments were made;
- any insurance company; or
- any other organization.

You will be required to cooperate with *us* to recover the overpayment.

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. *Subscribers* and their dependents living in the *HealthKeepers service area* will be eligible for coverage offered by *HealthKeepers*, while *subscribers* and their dependents living outside the *HealthKeepers* service area will be eligible for coverage offered by *Anthem*.

The employer will inform the *subscriber* of the *effective date*, which is agreed upon by *HealthKeepers*, *Anthem* and the employer.

The subscriber's eligible dependents

Eligible dependents include:

- the *subscriber's* spouse. For information on spousal eligibility please contact the *group administrator*;
- 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 a participating *physician's* certification of the *dependent's* condition.

Types of coverage

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

- Employee only
- Employee and spouse
- Employee and one child
- Employee and family

- Employee and children

When you may enroll

You may enroll:

- **During the initial enrollment period**
  The *subscriber* may enroll any eligible *dependents* by completing an application to be sent to *us* by the employer. No person whose coverage has been terminated for cause, as described in the fifth and seventh dot points in "Reasons for termination" in the **After coverage ends** section is eligible to re-enroll.
- **During open enrollment periods approved by HealthKeepers or Anthem**
  The coverage of people who enroll during the employer's open enrollment period is effective as agreed upon by the employer and us in the Group *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 us within 31 days of the newborn's birth. If an application along with any appropriate premium amount is not received by us 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 us 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.

We may periodically require proof of dependency.
Note: Any dependent, including a newborn child who is not enrolled 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*, *Anthem* 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. We are 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

Reasons for termination

Except as otherwise provided, *your* coverage may terminate in the following situations:

- When the *agreement* between the group and *us* terminates. If *your* coverage is through an association, *your* coverage will terminate when the agreement between the association and us terminates, or when *your* group leaves the association. It will be the group's responsibility to notify *you* of the termination of coverage. 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 us for such continuation of coverage. Upon termination of the extension of benefits, such a *member* shall have the right to convert to or continue coverage as outlined in the sections that follow.
- If *you* choose to terminate your coverage.
- If *you* or your dependents cease to meet the eligibility requirements of the plan, subject to any applicable continuation requirements under federal (COBRA) or state law. If *you* cease to be eligible, the group and/or *you* must notify *us* immediately. The group and/or *you* shall be responsible for payment for any services incurred by *you* after *you* cease to meet eligibility requirements.
- If *you* elect coverage under another carrier's health benefit plan, which is offered by the group as an option instead of this plan, subject to the consent of the group. The group agrees to immediately notify us that *you* have elected coverage elsewhere.
- If *you* perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of *your* plan, your coverage and the coverage of *your* dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of *your* coverage under the plan, just as if *you* never had coverage under the plan. *You* will be provided with a 31 calendar day advance notice before *your* coverage is retroactively terminated or rescinded. Such notice will contain clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact; an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact; notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission; a description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and the date when the advance notice ends and the date back to which the coverage will be rescinded. *You* are responsible for paying *us* for the cost of previously received services based on the *maximum allowed amount* for such services, less any *copayments* made or premium paid for such services. If *your* coverage is rescinded *we* will make an equitable adjustment of premium to *your* group, taking into account benefits that may have been paid. Please see *your* group concerning any refund to which *you* may be entitled.

- If *you* fail to pay or fail to make satisfactory arrangements to pay *your* portion of the premium, *we* may terminate *your* coverage and may also terminate the coverage of *your* dependents..
- If *you* permit the use of your or any other *member's* plan identification card by any other person; use another person's identification card; or use an invalid identification card to obtain services, *your* coverage will terminate following 31 calendar day written notice to the group. Anyone involved in the misuse of a plan identification card will be liable to and must reimburse *us* for the *maximum allowed amount* for services received through such misuse.

You will be notified in writing of the date *your* coverage ends by either *us* or the group.

Termination of the agreement

If the *agreement* between *HealthKeepers, Anthem* 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 *us* for such continuation of coverage. Upon termination of the extension of benefits, such a *member* shall have the right to convert or continue coverage as outlined in the sections that follow.

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 in the fifth and sixth dot points above, *you* are not eligible for reinstatement.

Continuing coverage when eligibility ends

A *subscriber* and enrolled dependents may be eligible for continuous group coverage under the COBRA law (Consolidated Omnibus Budget Reconciliation Act).

Continuation of coverage (COBRA)

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

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

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

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

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

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

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

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

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

When the qualifying event is:

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

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

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

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

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

- notice of the second *qualifying event* is properly given to the *plan administrator*; and

- the qualifying event would have caused the spouse or child(ren) to lose coverage under *your* health plan had the first *qualifying event* not occurred.

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

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

- the date that ends the maximum continuation period described above;
- the date that ends the last period for which a monthly payment was made when due;
- the date a *qualified beneficiary* becomes covered, after electing continuation of coverage, under another group health plan;
- the date the *qualified beneficiary* becomes enrolled in Medicare; or
- the date the employer's group health plan ends.

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

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

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

Other coverage options besides COBRA Continuation coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for *you* and *your* family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. *You* can learn more about many of these options at www.healthcare.gov.

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 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

Anthem Blue Cross and Blue Shield
Attention: Member Services
2015 Staples Mill Road
P.O. Box 27401
Richmond, VA 23279

Telephone:
800-582-6941

Written correspondence is preferable so that a record of *your* inquiry is maintained. When contacting *your* agent, HealthKeepers, Inc., or Anthem Blue Cross and Blue Shield 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 administrato*r 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 coverage

We 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*, *Anthem* and the employer. This may be done without the *member's* consent or concurrence.

Notice in writing

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

From you or your employer to HealthKeepers or Anthem. Notice by *you* or the *subscriber's* employer is considered "given" when actually received by *us*. *We* 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 *our* receipt of *your* complaint. If *we* are unable to resolve *your* complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve *your* complaint. We will then respond to *you* within an additional 30 calendar days. Written complaints may be filed to the following address:

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

Anthem Blue Cross and Blue Shield
Attention: Grievances and Appeals
2015 Staples Mill Road
P.O. Box 27401
Richmond, VA 23279

Grievance/appeal process

We are 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.

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 *we* 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. and Anthem Blue Cross and Blue Shield
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

Telephone:

800-582-6941

You must file *your* appeal within 180 days of the date *you* were notified of the *adverse benefit determination*.

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 we will handle your appeal
In reviewing *your* appeal, *we* will take into account all the information *you* submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing *your* appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving *medical necessity* will be reviewed by a clinical peer reviewer. 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 rescissions, *we* will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, *we* will respond to *you* and *your provider* as soon as possible taking into account *your* medical condition, but not later than 72 hours from 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 mandatory first level appeal is adverse to *you* and it was based on medical judgment, or if it pertained to a rescission of coverage, *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:

<u>Address:</u>
HealthKeepers, Inc. and Anthem Blue Cross and Blue Shield
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

<u>Telephone:</u>
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*, *Anthem*, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this 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 *us* more than one year after the date the cause of action first accrued with respect to any matter relating to:

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

The cause of action shall be deemed to have accrued 180 days after *our* initial decision if *you* do not initiate an appeal pursuant to *our* appeal process or an independent external review of an adverse utilization review

decision. Otherwise, the cause of action will be deemed to have accrued after the final decision of *HealthKeepers* or *Anthem* or through the external review process.

HealthKeepers and Anthem'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*.

Conformity with law

Any term of the plan which is in conflict with applicable federal laws and regulations, will hereby be amended to conform with the minimum requirements of such laws.

Our relationship to providers

The choice of a *participating provider* is solely the *member's*. *Our participating providers* are neither employees or agents of *HealthKeepers* or *Anthem*. *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 *participating 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 *participating provider*, nor are *we* responsible for a *participating provider's* failure or refusal to render *covered services* to a *member*.

Special limitations

The rights of *members* and obligations of *HealthKeepers* and *Anthem* 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 *our* control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of *covered services*, *we* 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, *we* and *our participating providers* shall render covered hospital and medical services insofar as practical, and according to their best judgment. *We* and *our participating 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 care *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 and
    - 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 Member Services 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 Member Services 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

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 or Anthem.

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

Anthem
refers to Anthem Blue Cross and Blue Shield, the insurance company administering coverage for eligible subscribers/dependents living outside the HealthKeepers service area.

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.

Biosimilar/Biosimilars

means a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Brand name drug
means 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 plan year before we will pay for any remaining services during that plan year.

Designated pharmacy provider
is an in-network pharmacy that has executed a designated pharmacy provider agreement with us or an in-network provider that is designated to provide prescription drugs, including specialty drugs, to treat certain conditions.

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

Emergency (Emergency medical condition)
Please see the **What is covered** section.

Emergency care
Please see the **What is covered** section.

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 our sole discretion. Refer to **Exhibit A** for more information.

Facility
includes but is not limited to, a hospital, freestanding ambulatory surgical facility, chemical dependency treatment facility, residential treatment center, skilled nursing facility, home health care agency or mental health facility, as defined in this EOC. The facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable or meet specific rules set by us.

Functional impairment
means limits on normal physical functioning that may include, but are not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts, or obstruction of an orifice. The cause of the physical functional impairment can be due to pain, structural, congenital or other means. Physical functional impairment excludes social, emotional, and psychological impairments or potential impairments.

Generic drugs
are prescription drugs that the PBM 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
refers to HealthKeepers, Inc., the health maintenance organization administering coverage for eligible subscribers/dependents living inside the HealthKeepers service area.

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.

Hospital

A provider licensed and operated as required by law, which has:

- Room, board, and nursing care;
- A staff with one or more doctors on hand at all times;
- 24 hour nursing service;
- All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
- Is fully accredited by The Joint Commission.

The term hospital does not include a provider, or that part of a provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial dare
- Educational care
- Subacute care
- Treatment of alcohol abuse
- Treatment of drug abuse

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.

Intensive outpatient program

means short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Interchangeable biologic product

means a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Maintenance medications

Please see the “Prescription drug benefit at a retail or home delivery (mail order) pharmacy” section for details.

Maintenance pharmacy

an in-network retail pharmacy that is contracted with our PBM to dispense a 90 day supply of maintenance medication.

Maximum allowed amount

is the allowance as determined by HealthKeepers or Anthem 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 us 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 non-HealthKeepers or non-Anthem provider.

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 use disorder, 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.

Partial hospitalization program

means structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Participating provider

is a provider who has contracted to participate in either the HealthKeepers or Anthem network. For members enrolled with HealthKeepers, a participating provider is a provider who has contracted to participate in the HealthKeepers network; for members enrolled with Anthem, a participating provider is a provider who has contracted to participate in the Anthem PPO network.

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

Is a process to make clinically based recommendations that will help you access quality, low cost medicines within your plan. The process includes health care processionals 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 include, but are not limit to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Physician

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

Plan administrator

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

Post-service claims

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

Pre-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 all of the 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 general or family practitioner, internist or pediatrician you choose to provide, arrange and/or authorize any health care services you and your family members may need.

Provider

is a medical group, physician, hospital, skilled nursing facility, pharmacy, or any other duly licensed institution or health professional who has contracted with HealthKeepers or Anthem 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 participating providers is made available to each subscriber prior to enrollment. A current list may be obtained from HealthKeepers or Anthem upon

request and may be seen by visiting our website page at www.anthem.com. The list shall be revised by us from time to time as we deem necessary.

Qualified beneficiary

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

Qualifying event

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

Referral

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

Residential treatment center / facility

A provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more doctors available at all times.
- Residential treatment takes place in a structured facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term residential treatment center/facility does not include a provider, or that part of a provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

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 you can get covered services from an in-plan provider. For the purposes of offering coverage and determining eligibility, the service area for Anthem and 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 care providers

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

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 or Anthem, and for whom the premium required by the agreement has been paid to HealthKeepers or Anthem.

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.

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.

Utilization review
means the evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

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.

We, us, our
refers to HealthKeepers and/or Anthem, unless specified elsewhere.

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 routine 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 of Health and Human Services 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.

All requests for clinical trials services, including 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; 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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Skilled Nursing Facility............................... 29,47

Speech Therapy...31,47

Spinal Manipulations..................................... 29

Spouses (or Dependents)................................64

Substance Use Disorder (or Mental health)......26

Supplies or Medical Equipment (Durable).......25

Surgery.. 29

Termination of Coverage (or Cancellation of Coverage)...68

Therapy...31,47

Transplants.. 30,46

Urgent Care...9

Weight loss.. 48

Well child... 27

Wellness services..27

X-ray (or Diagnostic Testing).......................... 19

End of Evidence of Coverage

Special features and programs

In addition to the health and wellness benefits under *your health plan*, *our* plans are designed to give *you* services, rewards and information to help *you* maintain and improve your health and reach your health potential.

Your health account

You may be offered the opportunity to establish a health account for your health account dollars. If *you* have the opportunity and choose to establish a health account, it will work like a bank account to give *you* control over a portion of the dollars *you* spend on your health.

When *you* establish a health account, the dollars in it are funded by your contributions, including pre-tax payroll deductions and post-tax deposits. Your employer may also choose to make contributions to your health account. *You* can continue to make contributions for as long as *you* remain enrolled in an HSA-compatible health plan. However, once *you* leave an HSA-compatible health plan, *you* can no longer make additional contributions to your health account.

You may use the dollars in your health account to pay for covered services subject to *deductible* and *coinsurance* amounts you incur while covered under this health plan. In addition, your health account dollars may be used for any medically qualified services and supplies as defined by the Internal Revenue Service HSA expenditures rules for medical and dental expenses. If health account dollars are used for things other than defined HSA expenditures, there may be tax implications. Please consult your tax advisor for information and advice.

Once established, the health account is totally portable. *You* control the account, and can build up the balance of dollars in the account over time. Any unused health care dollars can be rolled over year after year. If your coverage under this health plan ends for any reason, any balance of unused account dollars remains under your control, until the account is depleted.
Dollars are added to your health account as *you* earn rewards for participating in and/or completing certain lifestyle improvement programs. Please see **Rewards** in the section that follows for more details.

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.

Get help in your language

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

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

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

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bassa
Ɱ ɓéɖé dyí-ɓɛ̀ɖɛ̀ìn-ɖɛ̀ɔ̀ ɓɛ́ m̀ ké bɔ̃̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɖá mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ ɓɛ́ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

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

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

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

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

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

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

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

Urdu
ٓپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711).

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

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It's important we treat you fairly

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

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