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 intend 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.

<table>
<thead>
<tr>
<th></th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per member</td>
<td>Per family</td>
<td>Per member</td>
</tr>
<tr>
<td>Plan year deductible</td>
<td>$3000</td>
<td>$6000</td>
<td>$6000</td>
</tr>
<tr>
<td>The most you will pay per plan year</td>
<td>$4000</td>
<td>$8000</td>
<td>$10000</td>
</tr>
</tbody>
</table>

Summary of benefits continued
<table>
<thead>
<tr>
<th>Copayment</th>
<th>Coinsurance (after calendar year deductible)</th>
<th>Coinsurance (after calendar year deductible)</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detail</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of benefits continued
<table>
<thead>
<tr>
<th>Summary of benefits - 3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayment</td>
<td>Coinsurance</td>
<td>Coinsurance</td>
</tr>
<tr>
<td></td>
<td>(after plan year deductible)</td>
<td>(after plan year deductible)</td>
<td></td>
</tr>
<tr>
<td>Ambulance travel (air and water)</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Out-of-plan providers may also bill you for any charges that exceed the plan's maximum allowed amount.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Important Note:</strong> Air ambulance services for non-emergency hospital to hospital transfers must be approved through precertification. Please see the What is covered section for details.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance travel (ground)</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Out-of-plan providers may also bill you for any charges that exceed the plan's maximum allowed amount.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Important Note:</strong> 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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism services</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Applied behavior analysis</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>All other services for autism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood and administration of blood products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical trials</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic supplies, equipment, and education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests and services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For specific conditions or diseases at an emergency room or outpatient facility department.</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Dialysis treatments</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Doctor visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On an outpatient basis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Specialty Care Providers</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Online visits (other than mental health and substance use disorders)</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Early intervention services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>$0</td>
<td>0%</td>
<td>Covered at the in-plan benefit level</td>
</tr>
<tr>
<td><strong>Important Note:</strong> Out-of-plan providers may also bill you for any charges over the maximum allowed amount.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>100-visit plan year limit per member.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice care services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Summary of benefits continued
4 - Summary of benefits

<table>
<thead>
<tr>
<th></th>
<th>In-plan Copayment</th>
<th>In-plan Coinsurance</th>
<th>Out-of-plan Coinsurance</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary of benefits continued</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>Infusion services-outpatient services</strong></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Facility services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>Lymphedema</strong></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td><strong>Inpatient admission</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic tests</strong></td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Maternity related, such as ultrasounds and fetal monitor procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>Medical equipment (durable), devices, appliances, formulas, supplies and medications</strong></td>
<td></td>
<td></td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Medical equipment (durable), devices and appliances</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Medical formulas, supplies and medications</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Injectable medications</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Excludes allergy injections/serum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetics</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>Mental health and substance use disorder</strong></td>
<td></td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Inpatient admission (including residential treatment centers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per stay</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Partial day program</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Outpatient treatment (including online visits)</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional counseling</strong></td>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>For eating disorders</td>
<td></td>
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</table>

Summary of benefits continued
### Summary of benefits - 5

<table>
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<tr>
<th>Preventive care services</th>
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<th>Out-of-plan Coinsurance</th>
<th>Detail Page number</th>
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<tbody>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For children and adults</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing facility stays</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td><strong>Spinal manipulation and manual medical therapy services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td><strong>Surgery</strong></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Inpatient admission</strong></td>
<td></td>
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<tr>
<td></td>
<td>Facility services</td>
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</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional provider services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Outpatient treatment</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Facility services</td>
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<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
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<tr>
<td></td>
<td>Professional provider services</td>
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<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
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<tr>
<td></td>
<td><strong>Therapy – outpatient services</strong></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td><strong>Chemotherapy, radiation, cardiac rehabilitation and respiratory</strong></td>
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<tr>
<td></td>
<td>Facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Physical, speech, and occupational</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Facility services</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Professional provider services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Wigs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited to one wig per member per plan year</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Summary of benefits continued
Prescription drug retail pharmacy and home delivery (mail order) benefits

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.

<table>
<thead>
<tr>
<th>Pharmacy Type</th>
<th>Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail pharmacy (in-network and out of network)</td>
<td>30 days</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Home delivery (mail order)</td>
<td>90 days</td>
</tr>
<tr>
<td>Specialty pharmacy (in-network and out-of-network)</td>
<td>30 days*</td>
</tr>
<tr>
<td>*See additional information in the “Specialty drug copayments / coinsurance” later in this section.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription</th>
<th>Copayment / Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Rx prescription drugs as listed on the Expanded list</td>
<td>No copayment / deductible / coinsurance</td>
</tr>
</tbody>
</table>

Retail and specialty pharmacy copayments / coinsurance

<table>
<thead>
<tr>
<th>Tier 1 prescription drugs</th>
<th>Copayment</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Tier 2 prescription drugs</td>
<td>$30</td>
<td>0%</td>
</tr>
<tr>
<td>Tier 3 prescription drugs</td>
<td>$50</td>
<td>0%</td>
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Home delivery pharmacy copayments / coinsurance

<table>
<thead>
<tr>
<th>Tier 1 prescription drugs</th>
<th>Copayment</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Tier 2 prescription drugs</td>
<td>$75</td>
<td>0%</td>
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Summary of benefits continued
### Summary of benefits - 7

<table>
<thead>
<tr>
<th>Tier 3 prescription drugs</th>
<th>$125</th>
<th>0%</th>
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**Retail maintenance pharmacy copayments / coinsurance**

<table>
<thead>
<tr>
<th>Copayment</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 prescription drugs</td>
<td>$30</td>
</tr>
<tr>
<td>Tier 2 prescription drugs</td>
<td>$90</td>
</tr>
<tr>
<td>Tier 3 prescription drugs</td>
<td>$150</td>
</tr>
</tbody>
</table>

**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.
10 - How your coverage works

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.
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<table>
<thead>
<tr>
<th>Provider network status</th>
<th>Responsibility to get precertification</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>In plan</td>
<td>Provider</td>
<td>The provider must get precertification when required</td>
</tr>
<tr>
<td>Out of plan/ non-participating</td>
<td>Member</td>
<td>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.</td>
</tr>
<tr>
<td>Blue Card provider</td>
<td>Member (Except for inpatient admissions)</td>
<td>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.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Type of review</th>
<th>Timeframe requirement for decision and notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent pre-service review</td>
<td>72 hours from the receipt of request</td>
</tr>
<tr>
<td>Non-urgent pre-service review</td>
<td>15 calendar days from the receipt of the request</td>
</tr>
<tr>
<td>Urgent concurrent / Continued stay review when request is received more than 24 hours before the end of the previous authorization</td>
<td>24 hours from the receipt of the request</td>
</tr>
</tbody>
</table>
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)**
Preventing 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 woman, 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
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- 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:
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• 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.
What is covered - 35

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 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](http://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.

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.

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

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
What is not covered

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.
What is not covered

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 pharmaceutical adjuvants 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.
50 - What is not covered

- **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 offerd 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

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

Cooperation 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 administrator to provide the materials and pay you up to $110 a day until you receive the materials (unless the materials were not sent because of reasons beyond the control of the Administrator).
- If you have a claim for benefits or an appeal of a coverage decision, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court decides who pays court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim to be frivolous.

**Assistance**

If you have questions about your plan, contact your plan administrator. If you have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

**Changes in your 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:

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.
76-Important information about your coverage

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 appeal. You do not have to re-send the information that you submitted as part of the internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

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

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

All other requests for external review should be submitted in writing unless we determine that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:
Address:
HealthKeepers, Inc. and Anthem Blue Cross and Blue Shield
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

Telephone:
804-358-7390
in Richmond
800-421-1880
from outside Richmond

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

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

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

Limitations of damages
In the event a member or his representative sues HealthKeepers, 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 care
- 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 professionals such as nurses, pharmacists, and doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, member impact and financial value to make choices for the formulary. Our programs 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, chiroprist, 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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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
ወን友情链接 የተለምለ ይዘት ይፈን ከሚካከያ ጸሎት ከወን友情链接 ያለበት። ከማሸሚ ይርጠጥ መንጩ ከፈልጉ ከሚካከያ ሁኖ የመወሰን የምስክር ይሰው። (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
M bëdë dyĩ-bëdëin-dëbë m ké bš' nià ke gbo- kpá- kpá dyë dé m bïëti-wuqùùn bó pidyi. Bá mëbà jë gbo-gmë Kpë nëbë nià ni Dyĩ-dyoin-bëbë ké bë m ké gbo- kpá- kpá dyë. (TTY/TDD: 711)

Bengali
আপনার বিবেচনায় এই ভাষা পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষদে নমুনা কল করুন।(TTY/TDD: 711)

Chinese
您有权使用您的语言免费获取这些信息和协助。请拨打您的ID卡上的成员服务号码寻求协助。
(TTY/TDD: 711)

Farsi
پس 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 मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएं नंबर पर कॉल करें। (TTY/TDD: 711)

Igbo
I nwere ikike inweta ozi a yana enyemaka n'asusu gi n'efu. Kpọọ nomba Ọrụ Onye Otu di na kaachi NJ gi 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 kayuhang 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
کو کل کریم.. (TTY/TDD: 711)

Vietnamese
Quy 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 etó láti gba iwifún yií kí o si sèrànwọ ní édè rẹ lófèè. Pe Nòmbà àwọn ipèsè omo-egbè lórí káàdí idánimọ rẹ fún irànwọ. (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.