



■ Ready to choose *your benefits?*

We can point you in the right direction.

PPO Plan 3

Virginia Private Colleges Benefits Consortium: Hampden-Sydney
College

Effective January 1, 2017



You're ready to enroll. Let's take a look at your options.

In this guide, you'll find:

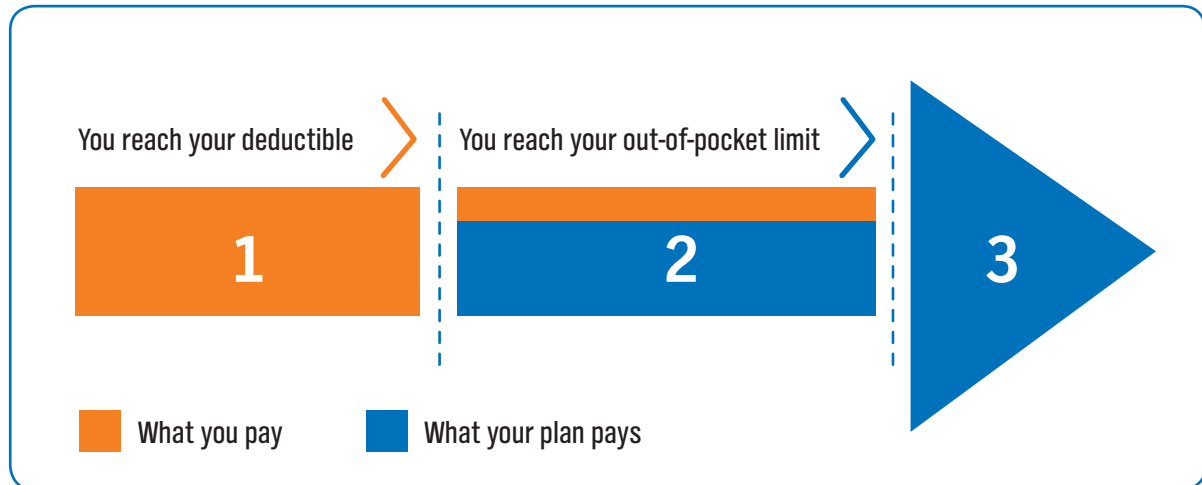
- How most health plans work
- Frequently Asked Questions (FAQ)
- Plan details
- Your privacy and rights





Getting started with health insurance

When you visit your doctor, it's important to understand how your health plan works.



- 1. You pay your deductible.** This is a set amount that you pay before we share the cost for covered health care. If your plan has **copays** (flat fees like \$30 for each visit) along with a deductible, you only need to pay the copay for most doctor visits.
- 2. After you meet your deductible, you'll only pay part of the cost.** You pay a copay or a percentage of the cost, also called coinsurance, each time you get care. Your plan covers the rest.
- 3. You're protected by your plan's out-of-pocket limit.** That's the most you pay for covered health services each year. With some plans, you still have copays even after you reach your out-of-pocket limit.
 - What about the money for your health plan that gets deducted from your paycheck? That's the payment for your plan. Think of it like a membership fee. It's separate from what you pay when you get care.
 - Remember, this chart is only an example. Your actual costs will depend on the type of plan you choose, the service you get and the doctor you choose. To see your actual costs, please refer to your plan information.



You can register at [anthem.com](https://www.anthem.com) or on the Anthem Anywhere mobile app — your simple and convenient solution to managing your health.

Frequently asked questions (FAQ)

Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your benefits if you choose a doctor in your plan. Some plans cover only services from doctors in your plan, which means you pay for the full cost if you see a doctor outside of the plan. Other plans cover services from doctors outside the plan — but your plan pays more of the cost when you see a doctor in your plan. Be sure to check the details of your plan.

To find out if your doctor is in the plan, or to find a new doctor in the plan, go to our *Find a Doctor* tool on [anthem.com](https://www.anthem.com). You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the doctors that serve your plan. You can also use *Find a Doctor* on your smartphone.

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

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor. You can also show a copy of your ID card from the Anthem mobile app.

Is preventive care covered?

Yes, preventive care from a doctor in the plan is covered at 100%. It's very important to take care of your health with regular checkups even when you feel fine. So talk to your doctor about screenings and immunizations that you may need to protect your health.

Can I manage my plan and health care on [anthem.com](https://www.anthem.com)?

Yes. As soon as you become a member, you'll be able to register at [anthem.com](https://www.anthem.com) or on the Anthem mobile app. It's designed to help you manage your health care and your benefits simply and conveniently. Many of our members find these self-service tools helpful:

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

Visit [anthem.com/guidedtour](https://www.anthem.com/guidedtour) to watch a video explaining how our website can help you.

Do I have health and wellness benefits with my plan?

Yes. In fact, we have a set of tools and resources that can help you reach your health goals. They can also save you money on products and services for your health.

Check out these health and wellness programs your employer is providing in addition to your health benefits:

24/7 NurseLine — Our registered nurses can answer your health questions wherever you are — any time, day or night.

Future Moms — Moms-to-be get personalized support and guidance from registered nurses to help them have a healthy pregnancy, a safe delivery and a healthy baby.

ConditionCare — Get the added support you may need if you have asthma, diabetes, heart disease, chronic obstructive pulmonary disease or heart failure. A nurse coach can answer questions about your health and help you reach your health goals based on your doctor's care plan. You can work with dietitians, health educators, pharmacists and social workers to reach those goals and feel your best.

Case Management — If you are hospitalized or have a serious health condition that needs extra care, a nurse care manager will help answer your questions, work to coordinate your care, and help you effectively use your health benefits.

How can Anthem help me save money?

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

At [anthem.com](https://www.anthem.com), you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products. You can even print your own coupons for healthier groceries. Check out these cost saving programs your employer is also offering.

LiveHealth Online — Using LiveHealth Online, you can have a video visit with a board-certified doctor or therapist on your smartphone, tablet or computer with a webcam. It's easy to



Frequently asked questions (FAQ)

use and there when you need it. All you have to do is sign up to use it at [livehealthonline.com](https://www.livehealthonline.com) or download the app.

Your plan details

In this next section, you'll find more information about your plan. 

PPO Plan 3

January 1, 2017 through December 31, 2017

This Schedule provides just a summary of the Covered Expenses, Limitations and Exclusions under the Plan. All benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, In Network discounts and Allowable Charges, as set forth in the Plan Document to which this Schedule is attached. Please read this Schedule only in conjunction with the Plan Document.

Benefits payable by the Plan may change depending upon whether Covered Services are obtained from a Participating Provider. The list of Participating Providers may change from time to time. A list of Participating Providers is located at www.anthem.com. Therefore, it is important to verify that the Provider who is treating you is currently a Participating Provider.

In-Network Services (Not subject to calendar year deductible)	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.	
* During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	No charge*
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <i>Plus – valuable discounts on eyewear</i> 	\$15 for each visit

All Other In-Network Services	You Pay
You will pay all the costs associated with your care until you have paid \$300 in one calendar year. This is known as your deductible.	
<ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay the first \$300 of the cost of your care (\$600 total). ○ If three or more people are covered under your plan, together you will pay the first \$600 of the cost of your care. However, the most one family member will pay is \$300. ○ The deductible is included in the out-of-pocket maximum. 	
Once you reach your deductible you pay:	
Doctor Visits	
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits ○ mental health conditions and substance use disorders visits ○ in-office surgery ○ physical and occupational therapy in an office setting (combined 30 visit limit per CY) ○ speech therapy visits in an office setting (30 visit limit per CY) ○ spinal manipulations and other manual medical intervention visits (30 visit limit per CY) ○ early intervention 	20% of the amount the health care professionals in our network have agreed to accept for their services
Maternity Benefits	
<ul style="list-style-type: none"> ○ all routine pre- and postnatal care (excluding inpatient stays) ○ diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures) 	20% of the amount the health care professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD)	
<ul style="list-style-type: none"> ○ Behavioral Health Treatment: mental health services 	Office Visit: 20% (after meeting deductible) Outpatient Facility: 20% (after meeting deductible) Inpatient Facility: 20% (after meeting deductible)
<ul style="list-style-type: none"> ○ Pharmacy Care 	Office Visit: 20% (after meeting deductible)
<ul style="list-style-type: none"> ○ Psychiatric Care 	Office Visit: 20% (after meeting deductible) Outpatient Facility: 20% (after meeting deductible) Inpatient Facility: 20% (after meeting deductible)

Autism Spectrum Disorder (ASD) – For children from age 2 through 6 (continued)	
<ul style="list-style-type: none"> ○ Psychological Care 	Office Visit: 20% (after meeting deductible) Outpatient Facility: 20% (after meeting deductible) Inpatient Facility: 20% (after meeting deductible)
<ul style="list-style-type: none"> ○ Therapeutic Care: unlimited physical, occupational and speech therapy 	Office Visit: 20% (after meeting deductible) Outpatient Facility: 20% (after meeting deductible)
<ul style="list-style-type: none"> ○ Applied Behavioral Analysis 	20% (after meeting deductible)
Labs, X-rays and Other Outpatient Services	
<ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays ○ dialysis ○ chemotherapy (not given orally) ○ radiation therapy ○ durable medical equipment ○ allergy testing ○ respiratory therapy ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ professional ground ambulance services ○ complex diagnostic imaging (requires pre-authorization) 	20% of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (combined 30 visit limit per CY) ○ speech therapy (30 visit limit per CY) ○ emergency room ○ surgery ○ physician services 	20% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> ○ home health care visits by a nurse or aide (90 visits) ○ hospice care ○ private duty nursing (16 hours per member per year)* <p>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.</p>	20% of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit (inpatient mental health/substance abuse admissions and maternity admissions included; requires pre-authorization) ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services ○ skilled nursing facility care (100 days for each admission and requires pre-authorization) ○ mental health conditions and substance use disorders partial-day treatment programs 	20% of the amount the health care professionals in our network have agreed to accept for their services

For benefits listed with specific limits all services received during the calendar year from January 1 and December 31 for that benefit are applied to that limit (whether received in or out-of-network). Your deductible amount begins anew on January 1 each year. Any amount you pay toward your deductible during the 4th quarter of each calendar year—October, November, December—will apply not only to your deductible for that year but will also apply to your deductible for the following year.

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$500 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first \$500 of the cost of your care (\$1,000 total).
- If three or more people are covered under your plan, together you will pay the first \$1,000 of the cost of your care. However, the most one family member will pay is \$500.
- The out-of-network deductible is not combined with the in-network deductible.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$500 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using network professionals

If you are the only one covered by your plan, you will pay \$2,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay \$2,000 (\$4,000 total).
- If three or more people are covered under your plan, together you will pay \$4,000. However, no family member will pay more than \$2,000 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay \$4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).
- If three or more people are covered under your plan, together you will pay \$8,000. However, no family member will pay more than \$4,000 toward the limit.
- The out-of-network out-of-pocket maximum is not combined with the in-network out-of-pocket maximum.

*The following do not count toward the calendar year out-of-pocket maximum:

- your share of the cost of prescription drugs and routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your PPO plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

*This benefits overview insert is only one piece of your entire enrollment package.
See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

“This booklet provides Anthem’s general exclusions and limitations which may vary from the Plan Document. Please consult the Virginia Private Colleges Benefits Consortium, Inc. Health Plan Document for a list of exclusions and limitations.”

**WELCOME TO
BLUE VIEW VISION!**

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what’s covered, your discounts, and much more!



**Blue View VisionSM
Exam Only A15 Plan**

Your Blue View Vision network

Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision’s network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you can maximize your benefits and money-saving discounts. Members may call Blue View Vision toll-free at the telephone number listed on the back of their ID card with questions about vision benefits or provider locations.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES

Routine eye exam – once every calendar year

IN-NETWORK

\$15 copay

OUT-OF-NETWORK

\$30 allowance

USING YOUR BLUE VIEW VISION PLAN

Just make an appointment for a comprehensive eye exam with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

OUT-OF-NETWORK


If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment at the time of service.

To Fax: 866-293-7373
To Email: oonclaims@eyewearspecialoffers.com
To Mail: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

This is a primary vision care benefit intended to cover only routine eye examinations. Benefits are payable only for expenses incurred while the group and insured person’s coverage is in force.

This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member’s policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

anthem.com

OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY		In-network Member Cost
Retinal Imaging	<ul style="list-style-type: none"> At member's option can be performed at time of eye exam 	Not more than \$39
Eyeglass Frame	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses* 	35% off retail price
Eyeglass Lenses Standard plastic material	<ul style="list-style-type: none"> When purchased as part of a complete pair of eyeglasses*: <ul style="list-style-type: none"> Single Vision \$50 Bifocal \$70 Trifocal \$105 	
Eyeglass Lens Options and Upgrades When purchasing a complete pair of eyeglasses* (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	<ul style="list-style-type: none"> UV Coating \$15 Tint (Solid and Gradient) \$15 Standard Scratch-Resistant Coating \$15 Standard Polycarbonate \$40 Standard Anti-Reflective Coating \$45 Standard Progressive Lenses (add-on to Bifocal) \$65 Other Add-Ons and Services 20% off retail price 	
Conventional Contact Lenses (non-disposable type)	<ul style="list-style-type: none"> Discount applies to materials only 	15% off retail price
SOME OF THE ADDITIONAL SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM		
	<ul style="list-style-type: none"> For this and other great offers, login to member services, select discounts, then Vision, Hearing & Dental 	Save \$20 on orders of \$100 or more and get free shipping
LASIK laser vision correction surgery	<ul style="list-style-type: none"> For this offer and more like it, login to member services, select discounts, then Vision, Hearing & Dental 	Discount per eye

* If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.

Cannot be combined with any other offer. Discounts on frames do not apply in the event the manufacturer has imposed a no discount policy on the frame. Discount on frames and special member pricing apply when complete pairs of eyeglasses are purchased together. If purchased separately, members receive a 20% discount off the retail price.

Discounts referenced are not covered benefits under the vision plan and therefore are not included in the member's policy. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. Discounts are subject to change without notice.

LiveHealth Online

Quick and easy access
to a doctor 24/7



Have you ever been at work and didn't feel well? Maybe you had a fever or a sore throat but you didn't have time to leave and see your doctor or go to urgent care. Now, with LiveHealth Online, you can see a board-certified doctor in minutes.

Just use your smartphone, tablet or computer with a webcam. It's so convenient, almost 90% of people who've used it feel they saved two hours or more and would use it again in the future.¹ Plus, online visits using LiveHealth Online are already part of your Anthem Blue Cross and Blue Shield benefits. To start using LiveHealth Online, all you need to do is sign up at livehealthonline.com or download the app.

Sign up for free today and get:

- 1. 24/7 access to doctors.** They can assess your condition, provide treatment options and even send a prescription to the pharmacy of your choice, if needed.² It's a great way to get care when your doctor isn't available.
- 2. Medical care when you need it.** For things like the flu, a cold, sinus infection, pink eye, rashes, fever and more.
- 3. Convenience.** Since there are no appointments or long waits. In fact, most people are connected to a doctor in about 10 minutes or less.

Doctors using LiveHealth Online typically charge \$49 or less per visit, depending on your health plan.

LiveHealth Online Psychology

An easy, convenient way to see a therapist or psychologist in just a few days

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using LiveHealth Online Psychology. It's easy to use, private and, in most cases, you can see a therapist within four days or less.³ All you have to do is sign up at livehealthonline.com or download the app to get started. The cost is similar to what you'd pay for an office therapy visit.

Make your first appointment – when it's easy for you

- Use the app or go to livehealthonline.com and log in. Select **LiveHealth Online Psychology** and choose the therapist you'd like to see.
- Or, call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m.
- You'll get an email confirming your appointment.



And Its Affiliate HealthKeepers, Inc.

LiveHealth
O N L I N E

LiveHealth Online: what you need to know

What kind of doctors can you see on LiveHealth Online?

Doctors on LiveHealth Online are:

- Board certified with an average of 15 years of practicing medicine
- Mainly primary care physicians
- Specially trained for online visits

When can you use LiveHealth Online?

LiveHealth Online is a great option for care when your own doctor isn't available and more convenient than a trip to the urgent care. With LiveHealth Online, you can receive medical care for things like:

- Cold and flu symptoms, such as a cough, fever and headaches
- Allergies
- Sinus infections and more

How do I pay for an online visit using LiveHealth Online?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online doctor visit. Keep in mind that charges for prescriptions aren't included in the cost of your doctor visit.

LiveHealth Online Psychology

What conditions can be treated when you have a visit with a psychologist or therapist?

You can get help for these types of conditions:

- Stress
- Anxiety
- Depression
- Family or relationship issues
- Grief
- Panic attacks
- Stress from coping with a sickness



How much does a therapist visit cost?

The cost should be similar to what you'd pay for an office therapy visit, depending on your benefits, copay or coinsurance. You'll see what you owe before you start a visit and any cost is charged to your credit card. The cost is the same no matter when you have the visit — whether it's a weekday, the weekend, evening or a holiday.

How do I decide which therapist to see?

After you log in at livehealthonline.com or with the app, select **LiveHealth Online Psychology**. Next, you can read profiles of therapists and psychologists. Once you select the one you would like to see, schedule a visit online or by phone. At the end of the first visit, you can set up future visits with the same therapist if both of you feel it's needed. You always have the choice of the therapist you want to see.

What else do I need to know about LiveHealth Online Psychology?

- You must be at least 18 years old to see a therapist online and have your own LiveHealth Online account.
- Psychologists and therapists using LiveHealth Online do not prescribe medications.
- Visits usually last about 45 minutes.

Get started today

It's quick and easy to sign up for LiveHealth Online. Just go to livehealthonline.com or download the mobile app at [Google Play™](https://play.google.com/store/apps/details?id=com.livehealthonline) or the [App StoreSM](https://apps.apple.com/us/app/livehealth-online/id1488888888).

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross and Blue Shield. Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

1 LiveHealth Online user feedback survey, May 2015.

2 Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to grow more in the near future. Please visit the map at livehealthonline.com for more details.

3 Appointments subject to availability of a therapist.

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.



Now you can take us on the go. Get our free mobile app!

Available on iPhones and Android smartphones.

On our app, you can:

- Find a doctor.
- Get to an urgent care center fast with maps and driving directions.
- Locate a hospital or emergency room.
- Access your Anthem Blue Cross and Blue Shield ID card on your phone.

Using our mobile app can help make it easier than ever to manage your health care.

1. Go to the app store on your smartphone or mobile device.
2. Search for Anthem Blue Cross and Blue Shield.
3. Select the app. Start the free download.

To use the mobile application, you must be registered on our secure member site and have a username and password. If you are an Anthem Blue Cross and Blue Shield member but have not registered for access to the secure member website, go to anthem.com from your computer and click Register Now.

Information that's important to you



And Its Affiliate HealthKeepers, Inc.

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices.
- HIPAA notice of privacy practices.
- Breast reconstruction surgery benefits.

Want to save more trees? Go to anthem.com and sign up to receive these types of notices by email.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. **Examples of ways we use your information for payment, treatment and health care operations:**

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit anthem.com/health-insurance/about-us/privacy for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide.

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities.
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents).
- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety.
- Special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Race, Ethnicity and Language: We may receive race, ethnicity and language information about you and protect this information as described in this Notice. We may use this information for various health care operations, which include identifying health care disparities, developing care management programs and educational materials and providing interpretation services. We do not use race, ethnicity and language information to perform underwriting, rate setting or benefit determinations, and we do not disclose this information to unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, including a request to receive a copy of your PHI through email. It is important to note that there is some level of risk that your PHI could be read or accessed by a third party when it is sent by unencrypted email. We will confirm that you want to receive PHI by unencrypted email before sending it to you.
- Ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem Blue Cross and Blue Shield (Anthem), Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not pre-empt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or coinsurance. Contact your plan administrator for more information.

For more information about the Women's Health and Cancer Rights Act, you can go to the federal Department of Labor website at: dol.gov/ebsa/publications/whcra.html.

EFFECTIVE March 1, 2016

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. are independent licensees of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Take care of yourself. Use your preventive care benefits.



And Its Affiliate HealthKeepers, Inc.

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.¹ When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Counseling for those ages 10-24, with fair skin, about ways to lower their risk for skin cancer
- Screening and behavioral counseling for tobacco use
- Vision screening² when done as part of a preventive care visit

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

Women's preventive care

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met³
- Breast-feeding: primary care intervention to promote breast-feeding support, supplies and counseling (female)^{4,5}
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening⁵
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV⁵
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield and its affiliate Healthkeepers, Inc. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.

Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision²
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years⁶
- Screening and counseling for obesity
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Screening and behavioral counseling for tobacco use
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles) for those 60 years and older

¹ The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your *Certificate of Coverage* or call the Customer Care number on your ID card.

² Some plans cover additional vision services. Please see your contract or *Certificate of Coverage* for details.

³ Check your medical policy for details.

⁴ Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

⁵ This benefit also applies to those younger than 19.

⁶ You may be required to get prior authorization for these services.



The ins and outs of coverage

Knowing that you have health care coverage that meets your and your family's needs is reassuring.

But part of your decision in choosing a plan also requires understanding:

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

Who can be enrolled

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

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

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

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

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

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

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

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



The ins and outs of coverage

(continued)

Special enrollment periods

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

However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

When you're covered by multiple plans

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

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



The ins and outs of coverage

(continued)

Determining the primary versus secondary carrier

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

When a person is covered by two group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	●	
	The plan with COB is		●
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	●	
	The plan covering the person as a dependent is		●
The person is the participant in two active group plans	The plan that has been in effect longer is	●	
	The plan that has been in effect the shorter amount of time is		●
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	●	
	The COBRA plan is		●
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent’s plan is	●	
	The noncustodial parent’s plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	



The ins and outs of coverage

(continued)

How benefits apply when Medicare-eligible

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

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

Recovery of overpayments

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

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



The following services and supplies will not be covered under your plan.

The ins and outs of coverage

(continued)

What's not covered (exclusions)

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

Applied behavioral therapy treatment

Your coverage does not include benefits for applied behavioral treatment (including but not limited to applied behavior analysis and intensive behavior interventions) unless otherwise covered by law.

Biofeedback therapy

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

Certain prescription drugs if you could use a **clinically equivalent drug**, unless required by law. If you have questions about whether a certain drug is covered and which drugs fall into this group, visit our website at anthem.com. If you or your doctor believes you need to use a different prescription drug, please have your doctor 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.

Cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance, including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause

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

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.
- Treatment of natural teeth due to accidental injury unless you submitted a treatment plan to us for prior approval. No approval of a plan of treatment by us is required for emergency treatment of a dental injury.
- Biting and chewing related injuries unless the chewing or biting results from a medical or mental condition.
- Restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth.
- Extraction of either erupted or impacted wisdom teeth.
- Anesthesia and hospitalization for dental procedures and services except as specified as otherwise being covered.
- Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures.
- Periodontal care, prosthodontal care or orthodontic care.



The ins and outs of coverage

(continued)

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

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

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

Family planning

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

Services for palliative or cosmetic foot care

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

- Fallen arches, weak feet, chronic foot strain
- Symptomatic complaints of the feet

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.

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

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

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

Home care services

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

Hospital services

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

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

Refills of **lost or stolen drugs**.



The ins and outs of coverage

(continued)

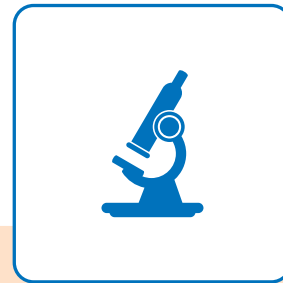
Medical equipment (durable), appliances, devices and supplies as outlined below:

- items that have both a non-therapeutic and therapeutic use, including but not limited to exercise equipment; air conditioners, 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. Reimbursement will be based on the maximum allowed amount for the standard item which is a covered service, serves the same purpose, and is medically necessary. Any expense that exceeds the maximum allowed amount for the standard item will be the member's responsibility.

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

Services or supplies deemed not **medically necessary** as determined by us at our sole discretion. Notwithstanding this exclusion, all preventive care services and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by us to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and

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



Experimental ... or not?

Many of our medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

- Regulatory approval from the Food and Drug Administration.
- Been put through extensive research study to find all the benefits and possible harms of the technology.
- Benefits that are far better than any potential risks.
- At least the same or better effectiveness as any similar service or procedure already available.
- Been tested enough so that we can be certain it will result in positive results when used in real cases.



The ins and outs of coverage

(continued)

Mental health and substance use

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

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

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

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

Off label use, unless we must cover it by law or if we approve it.

Organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the

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

Paternity testing

Prescription drug benefits

- Administrative charges: Charges for the administration of any drug except for covered immunizations as approved by us or the Pharmacy Benefits Manager.
- Clinically-equivalent alternatives - certain prescription drugs may not be covered if a member could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members will give 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, visit our website at 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.

- 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.



The ins and outs of coverage

(continued)

- Contrary to approved medical and professional standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery charges: Charges for delivery of prescription drugs.
- Drugs given at the provider's office/facility: Drugs you take at the time and place where you are given them or where the prescription order is issued. This includes samples given by the doctor. This exclusion does not apply to drugs used with diagnostic services, drugs used during chemotherapy in the office, or drugs covered under the medical supplied benefit; those would be covered services.
- Drugs not on the Anthem prescription drug list (a formulary): You can get a copy of this list by calling us or visiting us at anthem.com. If you or your doctor believes you need a certain prescription drug not on the list, please refer to the "prescription drug benefits at a retail or home delivery (mail order) pharmacy" section in your post enrollment *Evidence of Coverage* for details on requesting an exception.
- Drugs that do not need a prescription: Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs over the quantity or age limits: Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
- Drugs over the quantity prescribed or refills after one year: Drugs in amounts over the quantity prescribed, or for a refill given more than one year after the date of the original prescription order.
- Drugs prescribed by providers lacking qualifications/certifications. Prescription drugs prescribed by a provider who does not have the necessary qualifications, including certifications, as determined by us.
- Gene therapy as well as any drugs, procedures, health care services related to it that introduce or relate to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- Infertility treatments: Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- Items covered as durable medical equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers and blood glucose monitors. Items not covered under the prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit may be covered under the medical equipment (durable) or medical supplies benefit.
- Items covered the medical supplies and medications benefit: Allergy desensitization products or allergy serum. While not covered under the "prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy" benefit, these items may be covered under the medical supplies and medications benefit.
- Mail-order providers other than our home delivery mail-order provider: Prescription drugs dispensed by any mail order provider other than our mail order provider unless we must cover them by law.
- Non-approved drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless we must cover the use by law or if we, or the Pharmacy Benefits Manager, approve it.
- Onychomycosis drugs: Drugs for Onychomycosis (tonail fungus), except when we allow it to treat members who are immuno-compromised or diabetic.
- Over-the-counter items: Drugs, devices and products, or prescription legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device or product. This includes prescription legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over the counter products that we must cover under federal law with a prescription.
- Sexual dysfunction drugs: Drugs to treat sexual or erectile problems.



The ins and outs of coverage

(continued)

- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight loss drugs: Any drug mainly used for weight loss. This exclusion does not apply to over-the-counter products that we must cover as a preventive care benefit under federal law with a prescription.

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

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

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

Services or supplies or devices:

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

Services or supplies if provided or available to a member:

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

program the secondary payor after benefits under this plan have been paid.

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

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

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

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

Benefits for services or supplies to treat **sexual dysfunction** (male and female sexual problems). This includes medical and mental health services.

Skilled nursing facility stays

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

Smoking cessation programs not affiliated with us

Spinal manipulation and manual medical interventions for an illness or injury other than musculoskeletal conditions.

Telemedicine

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



The ins and outs of coverage

(continued)

Therapies

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

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

Vision services

- For members through age 18, there is no benefit for frames or contact lenses purchased outside of our formulary.
- Vision services or supplies, unless needed due to eye surgery and accidental injury
- Routine vision care and materials
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure
- Services for vision training and orthoptics
- Tests associated with the fitting of contact lenses, unless the contact lenses are needed due to eye surgery or to treat accidental injury
- Sunglasses or safety glasses and accompanying frames of any type

- Any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- Any lost or broken lenses or frames
- Cosmetic lens options that are not otherwise specifically listed as covered.
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- Any other vision services not specifically listed as covered

Waived cost shares

Your coverage does not include waived cost shares out-of-plan. For any service in which you are responsible under the terms of this plan to pay a copayment, coinsurance or deductible, and the copayment coinsurance or deductible is waived by an out-of-network provider.

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

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



Let's talk about your privacy and rights

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

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

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

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you

learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, visit www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.



You've got health goals.
We've got your back.

If you need more information

Member Services: 1.800.451.1527



And Its Affiliate HealthKeepers, Inc.

These policies have exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: Group Policy GP-1 (7/02), GP-TOC, GP-ELIG (1/14) and GP-GEN (1/17), PP-INTRO (1/17), P-TOC (1/15), P-SB6 (1/17), P-SB7 (1/17), P-WORKS (1/17), P-COVERED (1/17), P-EXCL (1/17), P-CLAIMS (1/17), P-COB (1/16), P-ENR (1/15), P-ENDS (1/17), P-INFO (1/17), P-RIGHTS (1/17), P-DEF (1/17), P-EXH-A (1/17), P-INDEX (1/14). Enrollment application used for these plans: 490773 (7/15). This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area. Life and Disability products underwritten by Anthem Life Insurance Company. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

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