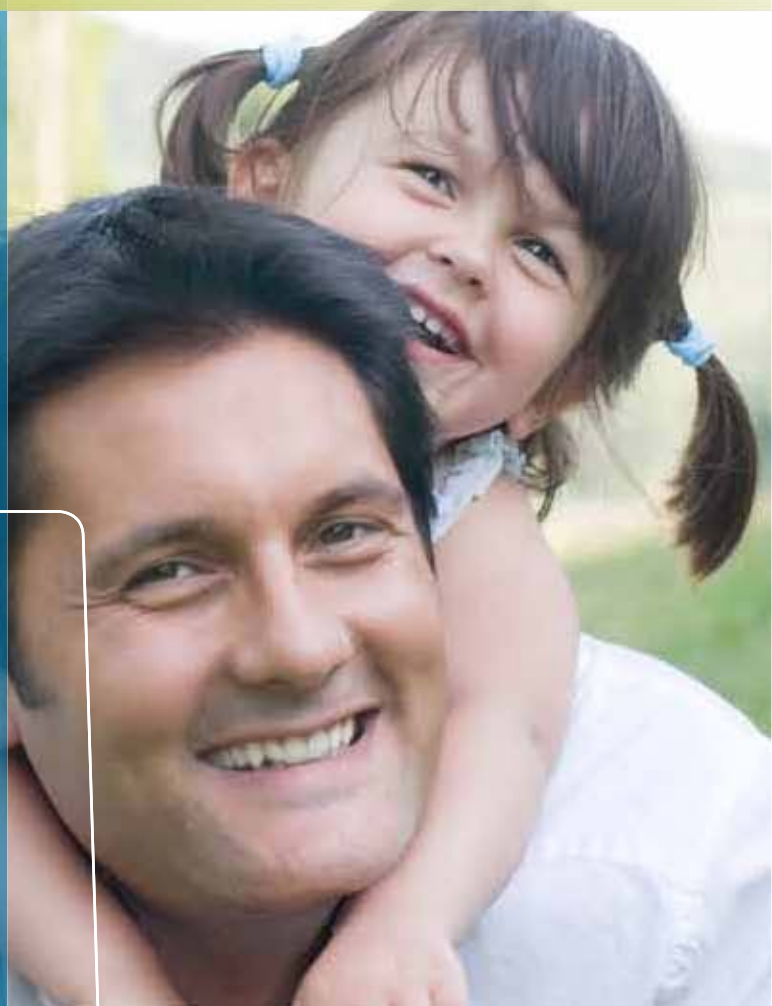
Anthem
Health. Join In.℠

Your KeyCare Plan

Council of Independent Colleges In Virginia
Benefits Consortium
Plan 3 PPO
Effective January 1, 2012

Choosing the right health plan is a very personal thing.



Use this book to find one that's

- Right for your lifestyle
- Right for your health
- Right for your peace of mind

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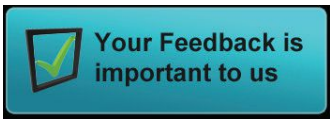
Your Feedback is
important to us

Your guide to Anthem Blue Cross Blue Shield benefits

Welcome! We're so glad you're taking time to check out all that Anthem Blue Cross Blue Shield (Anthem) has to offer you. Choosing your health care plan (and the benefits that go with it) is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with our Anthem plan. It shows what's available to you, what you get with each benefit and how the plan works.

Explore the advantages of being an Anthem member.

This booklet goes into all the advantages. But here are the top four:

1. **You're covered even when travel away from home.** You have access to the BlueCard® program and the BlueCard Worldwide® program so you'll be able to find an in-network doctor or hospital across the country or around the world if you need care. Wherever you travel, you can have peace of mind knowing you're covered.
2. **You get more than just basic coverage.** You get access to tools, resources and guidance that are personalized just for you. Plus there are programs to help you get and stay healthy, some are even online. They'll help you reach your personal goals to be as healthy as possible.
3. **There's so much you can do on our website – after all, it was created just for you.** If you have questions, you'll find the answers you're looking for. You can:
   - Order and print out a new member identification (ID) card if you lose yours,
   - Check the status of a claim
   - Find out how much a service costs
   - Search for a doctor, specialty, hospital or other health care professional
   - Learn about hundreds of health and wellness topics
   - And much more
4. **Finding an in-network doctor, specialist, hospital or a list of your medicines is a snap.** Just go our website and search the Online Provider Directory. Or call the Customer Service number on your member ID card. A customer service representative can give you information by phone, e-mail, fax or mail.

Once you get your member ID card, all it takes is three simple steps to discover the world of anthem.com.

- Go to anthem.com
- Click on Register
- Create your user name and password

Then you're ready to go!

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Your guide to Anthem Blue Cross Blue Shield benefits (continued)

We're on Facebook, Twitter and YouTube.

Did you know, that when you take better care of yourself, those around you will, too? Your health influences family, friends, even neighbors. (Studies prove it.) We're committed to helping you improve your health, wherever you go. And since you connect with friends, family, and coworkers – night and day, we've made it easy for you to connect with us.

Connect with Bob Harper from the television show *The Biggest Loser*.

We've teamed up with Bob Harper from the television show The Biggest Loser. Join us on the sites below for health, wellness and motivational ideas.

- Facebook.com/HealthJoinIn
- Twitter.com/HealthJoinIn
- YouTube.com/HealthJoinIn

At healthychat.com you can chat one-on-one about health care.

There's been a lot of talk about how health care is changing and how those changes impact every one of us. Join our conversations on this interactive website and learn about health care reform and health insurance

Please take a few minutes to look over the information in this booklet. And keep it handy for the future. If you have any questions, just ask your benefits manager. And thanks for considering us.

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Your Health Benefits

Anthem KeyCare PPO Plan

With no primary doctor requirement and no referrals, you're free to make your own decisions about your health care.

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

One, you have options. Anthem KeyCare is a PPO plan, which means you're free to choose your doctor without referrals. Of course, in-network care will usually cost less than out-of-network care. For many of our KeyCare plans, you'll also pay less when visiting a PCP instead of a specialist. The network includes most doctors and hospitals across the nation, so you'll find plenty of choices. The point is, the choice is yours.

Two, as an Anthem member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions – for you, your health and your budget.

Anthem KeyCare PPO at a glance

Primary Care Physicians (PCPs): Not required
You can make your own decisions about your doctors, your care and your costs.

Referrals: Not needed
You pick who you want to see. Makes getting second opinions very easy.

Claim Forms: No claim forms to submit when using network providers.

Out-of-Network Benefits: Available, but at lower coverage levels than in-network. We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.

Out-of-Pocket: This is the amount you'll pay, whether it is a straight copayment or some percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

Through **anthem.com**, you can estimate the costs for inpatient and outpatient services and doctor visits. What better way to help you determine what to do?

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency, urgent or approved follow-up care, you have three options. Go to **anthem.com**, call BlueCard® PPO Access at 800-810-2583 or call the customer service number on your member ID card.

How to find a network doctor

Anthem networks are some of the largest in the U.S. Simply go online and search our provider directory for the type of care you need.

1. Go to **anthem.com**.
2. Select "Find a Doctor."
3. Select your state.
4. Select the Anthem KeyCare PPO plan.
5. Select your provider type.
6. Select a specialist, if needed.
7. Enter your search criteria.
8. Click "View Results."

(continues on reverse)

Anthem KeyCare PPO Plan (continued)

You're getting more than a health plan

You get programs to actually help you manage your health. MyHealth@Anthem®, 360° Health® health management programs, and SpecialOffers@Anthem are all available through **anthem.com**. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your benefits summary contains the details. Thank you for considering Anthem Blue Cross and Blue Shield.

Anthem

Plan 3 - PPO

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	
o well-baby visits o immunizations o checkups o Pap tests o mammograms (annually age 35 and over) o gynecological exams o prostate exams o screening tests o Prostate Specific Antigen (PSA) tests	**No charge**
Routine Vision	
o annual routine eye exam ***Plus — valuable discounts on eyewear***	**$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. o If two people are covered under your plan, each of you will pay the first $300 of the cost of your care ($600 total). o 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. o The deductible is included in the out-of-pocket maximum. **Once you reach your deductible you pay:**	
Doctor Visits	
o office visits o urgent care visits o home visits o pre- and postnatal office visits o mental health conditions and substance use disorders visits o in-office surgery o physical and occupational therapy in an office setting (combined 30 visit limit per CY) o speech therapy visits in an office setting (30 visit limit per CY) o spinal manipulations and other manual medical intervention visits (30 visit limit per CY) o early intervention ($5,000 maximum per CY)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Maternity Benefits	
o all routine pre- and postnatal care (excluding inpatient stays) o 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
Labs, X-rays and Other Outpatient Services	
o diagnostic lab services o diagnostic x-rays o dialysis o chemotherapy (not given orally) o radiation therapy o durable medical equipment o allergy testing o respiratory therapy o shots and therapeutic injections o medical appliances, supplies and medications, including infusion medications o professional ground ambulance services o 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	
o physical therapy and occupational therapy (combined 30 visit limit per CY) o speech therapy (30 visit limit per CY) o emergency room o surgery o physician services	**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.

In-Network Services	You Pay
Care at Home	
o home health care visits by a nurse or aide (90 visits) o hospice care o private duty nursing ($500 maximum)* ***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.***	**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	
o semi-private room, intensive care or similar unit (inpatient mental health/substance abuse admissions and maternity admissions included; requires pre-authorization) o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services o skilled nursing facility care (100 days for each admission and requires pre-authorization) o 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

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.

Autism Spectrum Disorder and Early Intervention

(Autism Spectrum Disorder is for Employers with 51 or more Employees)

Covered Services	You Pay
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
Diagnosis of autism spectrum disorder; Treatment of autism spectrum disorder; o Behavioral Health Treatment* o Pharmacy Care o Psychiatric Care o Psychological Care o Therapeutic Care** * *Mental Health Services* ***Unlimited physical, occupational and speech therapy.*	Member cost shares will be dependent on the services rendered. Please refer to the Summary of Benefits.
Applied Behavioral Analysis o Limited to a $35,000 per member annual maximum.	20% after applicable deductible if any
Early Intervention – For children from birth through age 3	
o Limited to $5,000 per member annual maximum* **Unlimited physical, occupational and speech therapy*	Member cost shares will be dependent on the services rendered. Please refer to the Summary of Benefits.
Out-of-Network Services	
Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits	
If your plan includes out-of-network benefits and you receive covered services from a health care provider outside of our network, the out-of-network deductible and coinsurance applies as outlined in the Summary of Benefits.	

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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 Vision℠

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®, Target Optical®, JCPenney® Optical, Sears Optical℠, and Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you receive the greatest benefits and money-saving discounts.

Out-of-network services
Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward the eye exam and you pay the rest. (Network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Annual routine eye exam *(once every calendar year)*	$15 copayment	$30 allowance

DISCOUNTS
Savings on eyewear and accessories
When you visit a participating Blue View Vision eye care professional or vision center, you'll pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non-disposable) contact lenses as you would like. Take advantage of these savings –it means more money in your pocket!

BLUE VIEW VISION ADDITIONAL SAVINGS	MEMBER SAVINGS
Eye Glass Frame*	35% discount off retail*
Contact Lenses** Conventional (non-disposable)	15% off retail price
Standard Plastic Lenses* Single Vision Bifocal Trifocal	 You Pay: $50 You Pay: $70 You Pay: $105
Eyeglass Lens Options/Upgrades* – For those who like to add an extra touch to their eyewear! UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Progressive (Add-on to bifocal) Standard Anti-Reflective Coating	 You Pay: $15 You Pay: $15 You Pay: $15 You Pay: $40 You Pay: $65 You Pay: $45
Other Add-ons and Services Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

Discounts are subject to change without notice.

** If frames, lenses or lens options are purchased separately, members get a 20% discount instead.*
***Discount does not apply to fitting fees or services.*

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!

And – there's more! You also get access to discounts on other vision services through SpecialOffers. Visit anthem.com/specialoffers to learn more about these valuable savings.

Laser vision correction surgery
Glasses or contacts may not be the answer for every person. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK or PRK Laser Vision correction. For more information go to SpecialOffers at anthem.com/specialoffers and select Vision Care.

USING YOUR BLUE VIEW VISION PLAN
The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. Your out-of-pocket expenses related to the vision benefits do not count toward your annual out-of-pocket limit and are never waived, even if your annual out-of-pocket limit is reached.

Plan 3 - PPO $10/$35/$55 Prescription Drug Plan

Your Prescription Drug Benefits

Prescription coverage that's easy to understand. And, how about reducing how much you pay for your prescriptions? These are important to you—and—we're helping to make things better. But talk is cheap. Prescriptions aren't. Just look at how easy your plan is to use and the ways we're helping you save.

Your three-tier plan design

You've seen that prescription drugs come in all shapes and sizes. You probably also know they vary in cost. Prescription drugs are divided into three categories called tiers. Depending on which tier a prescribed drug falls into—that affects how much you pay.

First-tier drugs have the lowest copayment. This tier will contain low-cost or preferred medications and may include generic and single-source or multi-source brand drugs*.

Second-tier drugs have a higher copayment than those on the first tier. This tier contains preferred medications that generally are moderate in cost and may include generic and single-source and multi-source brand drugs*.

Third-tier drugs have a higher copayment than those on the second tier. This tier contains non-preferred or high-cost medications and may include generic and single-source or multi-source brand drugs*.

Drugs are assigned to tiers based upon clinical decisions made by your Anthem plan's National Pharmacy and Therapeutics Committee whose members include nurses, pharmacists, and physicians. The plan has sole discretion in assigning drugs to tiers and also reserves the right within its sole discretion to move any prescription drug from one tier to another.

Ways to get your prescriptions. It's simply up to you!

You can receive prescriptions in one of the following ways.

Visit a pharmacy

Visit a participating pharmacy and your Anthem identification card is all you need to access your benefits for your outpatient prescription drugs. With your card you can receive up to a 30-day supply of covered medication from any participating retail pharmacy. Thousands of pharmacies participate in Virginia, including most major chains. To find participating pharmacies near you:

- Go to anthem.com, click on Find a Doctor and then select Find a pharmacy near you.
- Call Anthem Member Services (as listed on your ID card).

Get home delivery

With Express Scripts, our mail order pharmacy, you can receive up to a 90-day supply of your covered maintenance medications (such as a medication for high blood pressure or high cholesterol), and your prescription is delivered directly to your home. Express Scripts mail order is easy to use and you'll receive simple, step-by-step instructions once you are enrolled.

Your source for specialty drugs

Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Often, these drugs require special handling such as temperature-controlled packaging and overnight delivery. Your CuraScript pharmacy will fill both mail order and retail (when available) prescriptions. With CuraScript, you get the convenience of a full-service pharmacy dedicated to improving healthy outcomes.

* Single-source drugs are manufactured by only one manufacturer while multi-source drugs are manufactured by several.

Plan 3 - PPO $10/$35/$55 Prescription Drug Plan

See the chart below for how much you'll pay by drug tier category			
For medications you need when you are not in the hospital, you can receive…	**First-tier Your Copayment**	**Second-tier Your Copayment**	**Third-tier Your Copayment**
Up to a 30-day medication supply from participating retail pharmacies	$10	$35	$55
Up to a 90-day medication supply delivered to your home	$10	$70	$110

Preparing to talk to your doctor is important, and you may want to have a list of the most commonly used drugs by tier to bring with you to your appointment. Simply visit anthem.com to download our list of the most commonly used prescription drugs.

Get a little extra care from our participating pharmacies

Every time you have a prescription filled at a participating pharmacy, your pharmacist helps safeguard your health with an automatic drug-to-drug interaction check. This confidential comparison between the prescription you've requested and prescriptions you've had filled at other participating pharmacies can help avoid unsafe interactions. It's a special feature available only when you visit participating pharmacies.

Trust your generics

If you've ever wondered if generic drugs are just as good as brands, rest assured—they are. The standards set by the U.S. Food and Drug Administration (FDA) require that the active ingredients in generic drugs be chemically identical to their brand-name counterparts and equal in safety, strength, and effectiveness.

The FDA also requires the same review and approval process as for existing brand name drugs.

Why are generics often cheaper?

Generics are often cheaper because they're based on existing FDA-approved brand-name drugs, and manufacturers don't have to pay as much for research, development, or advertising. Your prescription drug copayments are designed so that you'll pay less out-of-pocket when your prescriptions are filled with generic drugs. So for less money, you get an equally effective medication. Participating pharmacies will always dispense a generic drug if a generic drug is available unless you or your doctor requests a brand-name drug. If your doctor requests a brand name when a generic is available, you will pay only the brand name copayment. If generic is available and you request a brand name, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

About your costs

Your Anthem health coverage includes a feature that limits the amount you have to pay each year in copayments. The expenses you pay for prescription drugs do not count toward that limit. Your per-prescription costs—including copayments and any additional costs you pay if you request a brand-name drug—cannot be waived even if you meet your annual copayment maximum.

Note on Prior Authorization

Some drugs require prior authorization. Go to anthem.com, select Member on the blue panel, then Virginia, and Search the Drug List. For further information, call Member Services at the number on your ID card.

Please reference your plan benefit booklet for a complete listing of exclusions under this plan.

Anthem Blue Cross and Blue Shield receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem members. These credits are retained by Anthem as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

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.

Take care of yourself. Use your preventive care benefits.

Getting regular checkups and exams can help you stay well, catch problems early and may be lifesaving. Our health plans cover 100% of the services listed in this flier as preventive care.[1] This follows the health care reform law and state regulations. When you get these services from providers in the network, you don't have to worry about paying anything out of your own pocket for covered preventive care such as screenings, immunizations and exams. You may have to pay part of the costs if you use a provider outside the network.

Here's an overview of the types of preventive services we cover. Refer to your benefits summary to learn more.

Preventive versus diagnostic care

What's the difference? Preventive care is precautionary. Diagnostic care is used to find the cause of existing symptoms. For example, if your doctor suggests you have a colonoscopy because of your age, that's preventive care. But, if your doctor suggests a colonoscopy to see what's causing your symptoms, that's diagnostic care and you may need to pay part of the cost (this is your "cost share").

Child preventive care (birth to 18 years)

Preventive care physical exams are covered as well as the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Please ask your health care provider what's right for you.

Preventive physical exams

Age-appropriate screening tests may include:

- Newborn screenings
- Vision screening[2]
- Hearing screening
- Developmental and behavioral assessments
- Oral health assessment
- Screening for lead exposure
- Hemoglobin or hematocrit (blood count)
- Blood pressure
- Height, weight and body mass index (BMI)
- Cholesterol and lipid level screening
- Screening for depression
- Screening and counseling for obesity
- Behavioral counseling to promote a healthy diet
- Screening for sexually transmitted infections
- Pelvic exam and Pap test, including screening for cervical cancer

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Haemophilus Influenza type b (Hib)
- Polio
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Rotavirus

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Take care of yourself. Use your preventive care benefits. (continued)

Adult preventive care (19 years and older)

Preventive care physical exams are covered as well as the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Please ask your health care provider what's right for you.

Preventive physical exams

Age-appropriate screening tests may include:

- Eye chart vision screening[2]
- Hearing screening
- Cholesterol and lipid level screening
- Blood pressure
- Height, weight and BMI
- Screening for depression
- Diabetes screening
- Prostate cancer screening including digital rectal exam and PSA test
- Breast cancer screening, including exam and mammography
- Pelvic exam and Pap test, including screening for cervical cancer
- Screening for sexually transmitted infections
- HIV screening
- Bone density test to screen for osteoporosis
- Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Aortic aneurysm screening (men)
- Screenings during pregnancy (including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)
- Intervention services (includes counseling and education):
  - Screening and counseling for obesity
  - Genetic counseling for women with a family history of breast and/or ovarian cancer
  - Behavioral counseling to promote a healthy diet
  - Primary care intervention to promote breastfeeding
  - Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin)
  - Screening and behavioral counseling related to tobacco use
  - Screening and behavioral counseling related to alcohol misuse

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, tetanus, pertussis
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Zoster (shingles)

1 Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits
2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

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Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting Anthem's network with those of other Blue Cross and Blue Shield companies across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network — with just one added step.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com or call the member services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. (This is the additional step.) Call Anthem member services to verify your coverage.
3. Show your ID card at the time of service.

One additional step. No additional costs or hassles. You pay the same with any Blue Cross and Blue Shield provider as you would an Anthem network provider. Plus the provider will file your claims for you. Anthem will still mail your explanation of benefits so you can double check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.

Ins and Outs of Coverage

Tips for understanding your coverage

Knowing the "rules of the road" for the plan you have selected can make all the difference in getting the most value from your KeyCare coverage. Here are a few tips to keep in mind when seeking services.

Services that require advance reviews

While you can see any doctor or go to any hospital you like, there may be instances in which a test or procedure your doctor wants you to have may not be covered. To help you minimize unanticipated costs from a non-covered service, we work with our in-network providers to make sure that certain services go through an advance review process first. This way, you'll know upfront whether the service is going to be covered.

An explanation on how we define emergencies

An emergency is the sudden onset of a medical condition with such severe symptoms that a person with an average knowledge of health and medicine would seek medical care immediately because there may be:

- serious risk to mental or physical health
- danger or significant impairment of body function
- significant harm to organs in the body (heart, brain, kidneys, liver, lungs, etc.)
- danger to the health of the baby in a pregnant woman

USING IN-NETWORK PROVIDERS EQUALS SAVINGS

You need a checkup. Dr. Smith is an in-network doctor and he's agreed to a fee of $200 for the service. Because he's in-network, you will simply pay whatever amount you would owe under your specific benefits plan, whether it's a specific dollar amount or a percentage of what the doctor charged, like 20% of the $200. Instead you visit Dr. Jones, and he's not in our network. Dr. Jones charges $350 for a checkup. Now you will pay not only the set fee or percentage amount required under your particular benefits plan. You may also pay an additional $150 — the difference in cost between what the in-network doctor agreed to accept as a set fee compared to what the out-of-network provider charged. Same service — totally different amount that comes out of your wallet. See why it makes sense to shop around?

Note: The estimated costs are for illustrative purposes only.

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
- your domestic partner and children, if deemed eligible by your group

Coverage will end at the end of the month 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.

How Coverage Changes Are Handled

Your KeyCare coverage can be renewed, cancelled or changed on two different levels. The first is on the employer level, which would impact you and everyone else covered under your employer's plan. The second level impacts your coverage only — including your covered family members — and does not apply to any others covered under your employer's plan.

The Ins and Outs of Coverage (continued)

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

renewed	cancelled	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 KeyCare plan can be...

renewed	cancelled	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 cancelled 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 towards 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.

About Pre-Existing Conditions

(does not apply to children under the age of 19)

Have you been treated for or diagnosed as having a specific condition other than pregnancy? If you have been, did the diagnosis or treatment occur less than 6 months before the date you will begin coverage under your employer's group health plan or by the start of the waiting period required by your employer, whichever is earlier? If so, there is a month period when services may* not be covered for those specific conditions — often called "pre-existing conditions." All other covered services not related to the pre-existing conditions will be available beginning on your first day as a KeyCare member. If you or a covered family member have had breast cancer and have been disease-free for five years, it is not considered a pre-existing condition, even if you have had routine follow-up visits to monitor for recurrence within the past 6 months or during your employer's required waiting period.

* Your -month pre-existing period can be reduced by the number of months of "creditable coverage" you had before your group health plan coverage (or employer-required waiting period) starts. Creditable coverage is earned by having had coverage under most types of group or individual: health insurance programs

- HMO plans
- health service plans
- fraternal society plans, or
- publicly-sponsored plans like Medicare, Medicaid, State Children's Health Insurance

Program (S-CHIP) or TRICARE

You should receive proof of prior coverage (called a "certificate of creditable coverage") from either the employer with whom you had the coverage or the health care company that provided it. If you go more than 63 days without health care coverage, coverage before that 63-day break will not reduce your pre-existing period. So that we may reduce the pre-existing period by the amount of time you were covered under creditable coverage, we may require you to give us a copy of any certificates of creditable coverage that you have. If you do not have a certificate, but you have creditable coverage, we will help you get one from your prior plan or issuer. Contact Member Services either by phone or by the address listed on the back of this enrollment brochure.

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, 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 2 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 non-custodial 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	KeyCare is Primary	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; and
- any other organization.

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 from. 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.

acupuncture

biofeedback therapy

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

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.

dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem.

- cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth
- repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face
- dental services and appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer
- covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

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

The Ins and Outs of Coverage (continued)

EXPERIMENTAL ... OR NOT?

Many of the Anthem 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; and**
- **been tested enough so that we can be certain it will result in positive results when used in real cases.**

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

- 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 artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures
- drugs used to treat infertility

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
- bunions (except capsular or bone surgery)
- calluses
- care of toenails
- fallen arches
- weak feet
- chronic foot strain
- symptomatic complaints of the feet

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 care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

home care services

These services are not covered by your KeyCare plan.

- homemaker services
- 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

medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use:

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

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

services or supplies deemed **not medically necessary** as determined by Anthem at its sole discretion. This will not prevent a member from being able to appeal Anthem's decision that a service is not medically necessary.

The following exceptions qualify for coverage.

For inpatients:

1. services rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians or related outpatient services or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services
2. services rendered by your attending provider other than inpatient evaluation and management services. Inpatient evaluation and management services include routine

visits by your attending provider to review patient status, test results, and patient medical records and do not include surgical, diagnostic, or therapeutic services.

For outpatients:

services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. This exception does not apply if and when pathologist, radiologist or anesthesiologist assumes the role of attending physician.

mental health and substance abuse

- 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
- inpatient mental health treatments that meet the following criteria:
  - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospita
  - group psychotherapy when there are more than 8 patients with a single therapist
  - group psychotherapy when there are more than 12 patients with two therapists
  - more than 12 convulsive therapy treatments during a single admission
  - psychotherapy provided on the same day of convulsive therapy

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

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.

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

- over-the-counter drugs
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the allowable charge for that prescription
- drugs for weight loss
- stop smoking aids
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- any refill dispensed after one year from the date of the original prescription order
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies
- medicine furnished by any other drug or medical service

- medications used to treat sexual dysfunction (only applicable for groups who have selected a Generic Premium Options drug plan)

private duty nurses in the inpatient setting

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.

care from **residential treatment centers** or other non-skilled inpatient settings, except to the extent such setting qualified as a substance abuse treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care

services or supplies

- ordered by a doctor whose services are not covered under your health plan
- are of any type given along with the services of an attending provider whose services are not covered
- not listed as covered under your health plan
- not prescribed, performed, or directed by a provider licensed to do so
- received before the effective date or after a covered person's coverage ends
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies

- for travel, whether or not recommended by a physician
- given by a member of the covered person's immediate family
- provided under federal, state, or local laws and regulations including Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted.
- provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government

- received from an employer mutual association, trust, or a labor union's dental or medical department
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities

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
- self-administered services or self care
- self-help training
- biofeedback, neurofeedback, and related diagnostic tests

services or supplies primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered wellness services visit or screening

sexual dysfunction surgery or sex transformation services, including 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 manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions

telemedicine

- non-interactive telemedicine services, including audio only telephone, electronic mail message or facsimile transmission

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

vision services

- 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
- any blended lenses (no line), oversize lenses, progressive multifocallenses, photchromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses• services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entityany other vision services not specifically listed as covered
- any other vision services not specifically listed as covered

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.

Health, Wellness & Anthem Advantages

Get the most out of your health plan

anthem.com

Clear. Intuitive. Easy.

Save money and live better with tools that keep you informed, in control, and at your healthy best.

Health and wellness

Now it's easier than ever to improve your health and well-being. Simply log in at anthem.com. You have access to an array of innovative tools to help you manage your health and achieve your goals.

MyHealth Assessment
Your first step toward a healthier lifestyle

Gain personal insights into your current health, your health risks, and what you can do to enjoy a healthier life. You complete a confidential assessment of your health and health care status, then receive a health assessment score and risk profile based on your specific answers. You also get tips and actions to help you improve your health.

To use MyHealth Assessment:

- Visit anthem.com
- Click on "Health & Wellness"
- Under Health Assessment, select "Take my HA now"

MyHealth Record
Your health history in one secure location

Keep your medical records organized, secure and easily accessible for emergencies and everyday use. Enter your information such as dates of immunizations, tests and screenings, prescription and over-the-counter drugs you take, medical conditions and more. Print and share with your doctors to help avoid potential drug interactions and duplicative tests and procedures.

To use MyHealth Record:

- Visit anthem.com
- Click on "Health & Wellness"
- Under Health Assessment, select "Start your Health Record"

SpecialOffers
Discounts on health-related products and services

Get the most out of your health plan

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids, and audiology services, fitness center memberships, weight-loss programs and more.

To access all discounts:

- Log in at anthem.com
- Click on "Health & Wellness"
- On far right side of page, see "Discounts"
- Click on "Access your Discount"

Plans and benefits

Anthem.com makes complex information easy to understand and easy to use. That makes it easier to make the right decisions for you and your family.

Coverage Advisor℠
A customized comparison of your health care needs and costs

You have a wide range of Anthem health plans to choose from; Coverage Advisor helps you choose the right one for you and your family. It helps you forecast your health care needs and costs and provides you with a clear comparison of benefit plans. If you have a medical savings account, it can also recommend contribution amounts to help cover expenses.

To use Coverage Advisor:

- Log in at anthem.com
- Go to Resources under "Plans & Benefits"
- Select the Blue "Plans & Benefits" panel
- On the far right side, select "Access Coverage Advisors"

Claims look-up
Easy access to claims information

Stay on top of your medical claims with this easy online view. You can see the amounts charged to your medical savings account, the amounts paid by your traditional health coverage, or the amounts for which you're responsible. You may also choose to receive an email when a claim has been processed, instead of receiving notification by mail.

To look up a claim:

- Log in at anthem.com
- Click on "Plans & Benefits"
- On right side Welcome area, select "Check Claim Status"

Get the most out of your health plan

Online Provider Finder
The quick and easy way to find your doctor

Search for doctors, hospitals and other health care facilities quickly online. You can make your search more specific by choosing a specialty or entering the name of a doctor or facility. If you're away from home, you can also search our National Directory.

To search our online Provider Finder:

- Visit anthem.com
- Select "Find a Doctor" and simply follow the steps outlined on the screen

Temporary ID card
Use it until you get your permanent ID card

We know the peace of mind your member identification (ID) card brings you and your loved ones. That's why we've made sure you can have it wherever you go.

If you haven't received your permanent ID card yet and want to access health care services, you can print your temporary ID card online by logging on to **anthem.com**.* Your temporary ID card letter **expires 30 days after its issue date** and isn't meant to replace your permanent ID card, which you'll still receive.

*Not all members may be able to request a temporary ID card.

Not registered at anthem.com?
Sign up now for access to personalized service and resources. It's fast, easy and secure..

360° Health® programs

The programs you read about here come with your health plan. There is no extra cost for them.

To learn more about these programs online, log in to anthem.com and click on MyHealth@Anthem.

Take charge of your health and the choices you make

We all have different health needs. Maybe you're fit and want to stay that way. Maybe you're living with a chronic condition like asthma. Or maybe you fall somewhere in between. No matter where you fall, our 360° Health program is here to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

24/7 NurseLine

Round-the-clock access to health information can really help your peace of mind and your physical well-being. That's why we have Nurse Coaches ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach 24/7 NurseLine, just call the customer service number on your ID card and ask to speak to a 24/7 NurseLine representative.

Future Moms

We know your goal is to have a safe delivery and a healthy baby. That's why we offer Future Moms, a voluntary program to help you take care of your baby before you deliver. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues.
- A helpful book: *Your Pregnancy Week by Week*
- Tips and facts to help you handle any unexpected events
- A questionnaire to see if you're at risk for preterm delivery

360° Health® programs

- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative.

ConditionCare

If you or someone you love has an ongoing illness or health problem, let us help you get more out of life. Our ConditionCare nurses help people of all ages take care of the symptoms of asthma and diabetes. And they work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease. With ConditionCare you'll get the information you need to help you feel your very best. Our ConditionCare nurses gather information from you and your doctor. Then they create a personalized plan for you.

Information and support are as close as your phone. Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse.

Behavioral Health

Dealing with complex mental health and medical conditions can be confusing and frustrating. But you don't have to face them alone. Our two programs, Behavioral Health Care Management and Depression Care Management can help guide you through your mental and physical health care challenges. The programs' care managers are licensed mental health professionals. They'll work closely with you to make a plan that can help you meet your mental health goals and tackle any barriers that might get in the way. The care managers will also make sure that all of your doctors and anyone else giving you care are all working together so that you get the best care. They'll also help you get the most value from your health plan benefits.

To learn more, call the customer service number on your ID card and ask to speak to a Behavioral Health Resource representative.

Information You Should Know

Managing your care if you need to go to a hospital or get a specific medical treatment

If you or a family member needs a certain type of medical care (for example: surgery, a treatment done in a doctor's office, physical therapy, etc.), you may want to know more about the following programs and definitions. They may help you better understand how your benefits work and how your health plan manages your care in these types of situations.

Utilization Management

Utilization Management (UM) is a program that is part of your health plan that lets us make sure you're getting the right care at the right time. Our UM program is made up of a team of licensed health care professionals such as nurses and doctors who do medical reviews. The UM review team goes over the information we have received from your doctor or other health care provider to see if a surgery, treatment or other type of care that has been requested is medically needed. The UM review team checks to make sure that the treatment meets specific rules set by your health plan. After reviewing the records and information, the surgery or treatment will be approved (covered) or denied (not covered) and the UM review team will let you and your doctor know as soon as possible.

Medical reviews like this can be done before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before medical care is given)
A prospective review is done before a member goes to the hospital or has some other type of service or treatment.

Here are some types of medical needs members may have that might call for a prospective review:

- To go to (and/or stay at) a hospital
- An outpatient procedure (the member can go home the same day)
- Tests done to try to find the cause of an illness such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans
- A certain type of outpatient therapy such as physical therapy or emotional health counseling
- "Durable medical equipment" (DME) which means wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)
A concurrent review is done at the time the member is in the hospital or is released and needs more care related to the hospital stay. This could mean services or treatment done in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment (see above), staying in a nursing home, getting emotional health care and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

Managing your care if you need to go to a hospital or get a specific medical treatment

The retrospective or post-service review (done after medical care is given)
A retrospective review is done when a member has already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at the member's medical information that the doctor or provider had at the time the medical care was given. They can then see if the treatment was medically needed.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions, and help you better understand your health benefits.

Your rights and responsibilities as an Anthem Blue Cross Blue Shield member

As Anthem Blue Cross Blue Shield Anthem Blue Cross Blue Shield (Anthem) member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - — Your health care plan
  - — Any care you get
  - — Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.

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Your rights and responsibilities as an Anthem Blue Cross Blue Shield member (continued)

- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

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Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross and Blue Shield 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 co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

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 example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

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: 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, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for 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. PHI can also be shared 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. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

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: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or 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 them 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.

Important legal information you should take time to read (continued)

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They 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.

How we protect information

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

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 offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The 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 non-affiliates 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.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, 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.

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. They 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.

Important legal information you should take time to read

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: **Anthem Blue Cross and Blue Shield**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

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 judgements 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.

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

Health care reform and your plan

What's changing and when?

You've probably heard a lot of people talk about health care reform lately. But you may have questions about what it all means for you and your family – questions that even your news junkie neighbor can't answer.

JOIN IN.

To share your thoughts and ask questions about health care reform, visit healthychat.com.

Here's a quick summary of how the new law may affect your group health plan within the next year. Keep in mind that other employers' plans may have different rules. If you have questions about your specific benefits, call the customer service number on your member ID card or contact your group benefits administrator for a number to call.

When you enroll:

You'll have a chance to add young adult dependents to your plan

The federal health care reform law allows children to stay on their parent's or guardian's health plan until their 26th birthday. In some states, dependents can stay on the plan even longer. To be eligible for this coverage, children do not need to be financially dependent on you for support, claimed as dependents on your tax return, residents of your household, enrolled as students or unmarried. If you have dependents younger than 26 who aren't on your plan now, you can add them to your plan during your next open enrollment. If your plan already covers dependents up to age 26, you don't have to do anything. They'll stay on your plan automatically.

After your plan's effective date:

Kids under 19 can get coverage even if they have health conditions

The law says group health plans and insurers can't have pre-existing condition exclusions for children under the age of 19. Healthcare.gov, a website run by the federal government, defines a pre-existing condition as "a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan." Very few group health plans deny coverage altogether because of pre-existing conditions. However, some plans still have waiting periods for members who have pre-existing conditions. A waiting period means certain benefits aren't available right away.

You may have more flexibility in choosing doctors

This part of the law applies to you only if your plan requires you to select a primary care provider (PCP) and get referrals from your PCP to see a specialist. If you have this type of plan, you'll have the right to choose any primary care provider as your PCP, as long as the provider is in our network and will accept you or your family members. If your plan covers children, you may choose a pediatrician as their primary care provider. Also, you don't need prior approval from the plan or a referral from your primary care provider to get obstetrical or gynecological care from an in-network OB-GYN.

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Health care reform and your plan (continued)

Your plan's dollar limits may change

In the past, plans could have a "lifetime maximum" – a dollar limit on what the plan will pay for health care services over your lifetime. If your plan had a lifetime maximum, it's gone now. However, you should know that other limits may still apply. For example, you may have limits on certain services that aren't considered "essential health benefits." Also, you may have limits on how many times you can use a benefit during the year.

WHAT'S NEXT?

We don't want to overwhelm you, so this list only includes changes that may affect you within the next year. Other changes will take place through 2018, such as:

- **Guaranteed coverage for people of all ages – not just children – regardless of their health**
- **Health insurance exchanges where people who buy individual coverage and people who work for small businesses can shop for a plan**
- **Information on your W-2 tax statement about how much your employer paid for your health plan**
- **Changes to make health care more affordable for people who have Medicare**

If you want to know more, you can get the latest information about health care reform at healthychat.com.

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Once you're a member, it's easy to get answers to any questions about your health plan.

Just call the number on the back of your member identification (ID) card after you get it.

Anthem

Health. **Join In.**℠

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. 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: PP-INTRO (7/11), P-TOC (07/10), P-SB1 (7/11), P-SB2 (7/11), P-WORKS (10/10), P-COVERED (10/10), P-EXCL (10/10), P-CLAIMS (10/10), P-COB (07/10), P-ENR (10/10), P-ENDS (10/10), P-INFO-(7/11), P-RIGHTS (7/09), P-DEF (10/10), P-EXH-A (10/10), P-INDEX (07/10), P-ACC (07/10), GP-1 (7/02), GP-1-TOC, GP-1-ELIG (7/07), GP-1-GEN (1/08)

Enrollment applications used for Anthem KeyCare: 490760 (10/10), 490773 (10/10)

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.

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.

Visit us online at anthem.com