Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Your Anthem HealthKeepers

Culpeper County
Culpeper County Schools
Anthem HealthKeepers Open Access
HealthKeepers 25/1000
Effective October 1, 2012

Choosing the right plan is a very personal thing.

Use this book to find one that's

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

24677MUMENMUB 9/11

Please share your feedback with us in this short survey.

Welcome to Anthem HealthKeepers benefits

We're glad you're taking time to check out all that Anthem HealthKeepers has to offer you. Choosing your benefits is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with Anthem HealthKeepers coverage. It shows what's available to you, what you get with each benefit and how the plans work.

Explore the Anthem HealthKeepers membership advantage.

We know you're busy. That's why we've made sure it only takes a few moments to explore the advantages of being an Anthem HealthKeepers member, including:

- There's a good chance your doctor is part of Anthem HealthKeepers' network. To find out, go to anthem.com and search the provider directory.
- You get more than access to coverage. You also get tools, resources and guidance that may help you reach your personal, healthy best.
- Anthem.com has the answers you need. Simply go to anthem.com for answers to your claims questions and find detailed health benefit information.
- This booklet goes into all this — and more. Please take a few minutes to look over the information, and keep this booklet. It may come in handy.

Registering on anthem.com is step one.

Once you get your ID card, registering is easy; all you need is your ID card, the Internet and five minutes. After you register at anthem.com, you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

- Go to anthem.com
- Enter the site by clicking on Member
- Follow instructions to create your user name and password and you're ready to go!

Read on for information to help you choose your benefits with confidence. If you have any questions, your benefits manager will be happy to answer them. Thanks for considering Anthem HealthKeepers.

12597VAMEN POD 2/10

How to choose a health care plan that's right for you

Choosing the health care plan that's right for you and your family can be a tough decision. There are so many options and so many words, phrases and abbreviations to learn. And while it can be quite confusing, it's important that you take the time to learn all you can so you can make the best choice to meet your specific needs. The plan you choose will make a difference in how much you spend on your health care during the year. That's why we suggest you take your time to carefully think about your needs and options. And we're here to help.

Ask these questions when choosing a health care plan:

Does the plan:

- Have special programs to help you if you suffer from asthma, diabetes or other ongoing conditions?
- Cover physical exams, shots and health screenings to help you stay healthy and avoid a health problem?
- Give you information such as brochures, newsletters or online tools about healthy living?
- Offer tools to help you manage your health, as well as your benefits?
- Offer discounts on goods and services to improve your health?

Learn about the Anthem HealthKeepers difference

At Anthem HealthKeepers, we put our members first. We're dedicated to helping them get and stay healthy. Visit anthem.com to learn more about all we have to offer – from our large, strong networks to our personal health programs to the many ways we can help you save money while getting as healthy as possible.

Know the basic differences between the types of plans.

You may have a choice of health care plans at work or within your family. Knowing how the different plans work will help you pick the plan that best fits your family needs and budget.

- **Health Maintenance Organization (HMO)** — gives you access to a wide-range of services with low copays and low out-of-pockets costs. An HMO gives you coverage only for the doctors, hospitals and other health care professionals (providers) that are in the plan's network. But by staying in-network, you save the most money. You must choose a PCP who gives general care and will give you referrals when you need to see specialists. When you choose an HMO, make sure the plan has a big network so your own doctor will most likely be in it.

Here are some definitions:

Deductible: The amount you must pay each year before your plan pays anything. There may be a deductible for health care and a separate one for prescription drugs. Not every plan has a yearly deductible.

20225ANMENABS 1/12

How to choose a health care plan that's right for you (continued)

Coinsurance: An amount that you pay after you have met your plan's deductible. The plan pays a certain amount and you pay a certain amount.

Copay: The amount that you pay each time you see a doctor, get a prescription filled or get other services. A copay is a flat fee, like $20 for a doctor visit. Most HMOs have co-pays.

Understand the total costs.

Health care plans differ in many ways but with every plan, there's a basic premium, which is how much you and your employer each pay to buy the plan's coverage. The premium may only be a small part of your total cost. There are other payments you may make, which vary by plan. When choosing a plan try to figure out what the total cost is to you and your family, especially if someone in your family has a chronic or serious health condition.

Think about the following:

- Are there deductibles you must pay before the plan begins to help cover your costs?
- Are there office visit, emergency room or inpatient hospital copays?
- What is the coinsurance, meaning what part of the cost for other services do you have to pay out of your own pocket? If you use doctors that are out-of-network, how much more will you have to pay to get care?

To see the types of costs that come with our different health care plans, take a look at the Summary of Benefits. Your benefits manager can get you a copy for each type of plan if you don't already have one.

Table of Contents

Page

Your Health Benefits 1
Ins and Outs of Coverage 32
Information You Should Know 47

Your Health Benefits

13228WPMEN 4/10

Anthem HealthKeepers

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.

Care is guided by your doctor, who will also coordinate referrals for specialist care.

One, you have options. Anthem HealthKeepers is an HMO plan, which means benefits are typically covered when visiting in-network providers, except for emergency services. The network includes many doctors and hospitals across Virginia, so you'll find plenty of choices. Your primary doctor can guide you through all of your choices.

Two, as an Anthem HealthKeepers 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 HealthKeepers at a glance

- *Primary Care Physicians (PCPs):* Required
  Your PCP provides preventive care and can be an advocate for helping you decide what types of specialist services may be of value to you.
- *Referrals:* Needed for most specialty services, but specialty services related to preventive care benefits can be coordinated on your own.
- *Claim Forms:* No claim forms to submit when using network providers.
- *Out-of-Plan Benefits:* Not available except for emergency services
  While the plan doesn't cover out-of-network care, your doctor of choice is most likely in our network or another network specialist can be found to fit your needs.
- *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?

01617VAMEN Rev. 3/12

Anthem HealthKeepers (continued)

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® Access at 800-810-2583 or call the customer service number on your member ID card.

You're getting more than a health plan

You get programs to actually help you manage your health. Wellness tools, 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 HealthKeepers.

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. Enter your city and state or zip and click on "Search."
4. To see only a list of network providers, scroll down to "Insurance Options" and select "Add/Edit Selections."
5. Enter your state, select the HMO plan, then select "Anthem HealthKeepers" and click on "Search."

01617VAMEN Rev. 3/12

Anthem HealthKeepers Open Access plan

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 HealthKeepers Open Access is an HMO (health maintenance organization) plan with a direct access feature, which means you're free to seek specialist care without getting a referral first. You'll also typically pay less when visiting a PCP instead of a specialist. The Anthem HealthKeepers network includes many doctors and hospitals across Virginia, so you'll find plenty of choices. The point is, the choice is yours. Two, as an Anthem HealthKeepers 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 HealthKeepers Open Access at a glance

- *Primary care physicians (PCPs):* Required
  Your PCP provides preventive care and helps you make decisions about your health. Want to change PCPs? No problem. Since your plan includes an Open Access provision, you can visit any in-network primary care physician. Of course, having an established PCP relationship can make it easier to handle health issues as they come up since they'll already know your history and can possibly help direct you on getting the right type of specialist care.
- *Referrals:* Not needed.
- *Claim forms:* No claim forms to submit when using network providers.
- *Out-of-plan benefits:* Not available except for urgent and emergency services
  While the plan doesn't cover out-of-plan care, your doctor of choice is most likely in our network or another network specialist can be found to fit your needs.
- *Out-of-pocket:* This is the amount you'll pay, whether it is a straight copayment, deductible 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?

14245VAMENABS Rev. 3/12

Anthem HealthKeepers Open Access plan (continued)

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® Access at 800-810-2583 or call the customer service number on your member ID card.

You're getting more than a health plan

You get access to valuable discounts as well as programs to actually help you manage your health. Wellness tools, 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 HealthKeepers.

HOW TO FIND A NETWORK DOCTOR

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. **Enter your city and state or zip and click on "Search."**
4. **To see only a list of network providers, scroll down to "Insurance Options" and select "Add/Edit Selections."**
5. **Enter your state, select the HMO plan, then select "Anthem HealthKeepers" and click on "Search."**

Culpeper County and Schools 2012-2013 Benefit Plan Options

	HEALTHKEEPERS 25/1000	LUMENOS HSA 4
DEDUCTIBLE	$1000/$2000	$1500 individual/$3000 family
OUTPATIENT OFFICE VISITS • PCP • Specialist	AFTER PLAN YEAR DEDUCTIBLE $25 $50	10% after plan year deductible
PREVENTIVE CARE · Check ups, GYN exam & pap test · Prostate exam & PSA · Mammography screenings · Screenings/ Immunizations · Colorectal cancer screenings	 100% AC 100% AC 100% AC 100% AC 100% AC	 100% AC 100% AC 100% AC 100% AC 100% AC
WELL BABY CARE - Check-up visits - Screening tests - Immunizations	 100% AC 100% AC 100% AC	 100% AC 100% AC 100% AC
ANNUAL VISION EXAM	$15 co-pay $30 OON allowance	$15 co-pay $30 OON allowance
DIAGNOSTIC TESTS [1] ADVANCED DIAGNOSTIC IMAGING	AFTER PLAN YEAR DEDUCTIBLE $25 PCP/$50 Spec AFTER PLAN YEAR DEDUCTIBLE $150	10% after plan year deductible 10% after plan year deductible
PHISYCAL THERAPYT/OCCUPATIONAL THERAPY/SPEECH THERAPY [2]	AFTER PLAN YEAR DEDUCTIBLE $25 co-pay	10% after plan year deductible
OUTPATIENT SURGERY [3]	AFTER PLAN YEAR DEDUCTIBLE $150	10% after plan year deductible
PRE/POST NATAL CARE [4]	AFTER PLAN YEAR DEDUCTIBLE $300	10% after plan year deductible
OUTPATIENT MENTAL HEALTH/SUBSTANCE ABUSE VISITS	AFTER PLAN YEAR DEDUCTIBLE $20 (grp therapy, indiv therapy up to 30 min and med mgmt) $30 (all other visits)	10% after plan year deductible
INPATIENT HOSP. SERVICES	AFTER PLAN YEAR DEDUCTIBLE $300 day/not to exceed $1500 per admission	10% after plan year deductible
SKILLED NURSING [5]	AFTER PLAN YEAR DEDUCTIBLE 20%	10% after plan year deductible
DURABLE MEDICAL EQUIP	AFTER PLAN YEAR DEDUCTIBLE $0	10% after plan year deductible
AMBULANCE SERVICES	AFTER PLAN YEAR DEDUCTIBLE $100 per transport	10% after plan year deductible
EMERGENCY ROOM [6]	AFTER PLAN YEAR DEDUCTIBLE $250	10% after plan year deductible
OUT-OF-POCKET [7]	$4000/$8000	$3000/$5950
PRESCRIPTION DRUG Retail Mail Order	 $10/$30/$50 or 20% $20/$60/$100 or 20% $3500 OOP	 10% after plan year deductible 10% after plan year deductible

[1] If rendered with an office visit the member will only be responsible for an office visit co-payment
[2] 30 combined PT/OT visits and 30 ST visits (per member per plan year)
[3] Free standing ambulatory surgery center or hospital based facility
[4] All routine outpatient pre- and postnatal care of the mother rendered by the OB/GYN
[5] 100 days per admission
[6] Covered only for true emergency services; co-pay waived if admitted
[7] Individual/Family; Does not include co-payments/coinsurance/deductibles for prescription drugs, vision benefits or dental rider benefits

DEFINITIONS

Allowable charge (AC)	is the amount Anthem will pay for a service
Coinsurance	is the percentage of the allowable charge that you pay for some covered services.
Co-payment	is the fixed dollar amount you pay for most covered services, such as a doctor's visit.
Deductible	is a fixed dollar amount of covered services you pay in a calendar year before your health plan will pay for any remaining covered services during that calendar year.
Diagnostic Tests	• radiology (including mammograms), ultrasound or nuclear medicine; • laboratory and pathology services or tests; • diagnostic EKGs, EEGs; and • advanced diagnostic imaging services (MRI/CT scan).
Emergency	is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity; this includes severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in: • serious jeopardy to the mental or physical health of the individual; • danger of serious impairment of the individual's body functions; • serious dysfunction of any of the individual's bodily organs; or • in the case of a pregnant woman, serious jeopardy to the health of the fetus.
Inpatient	refers to a person receiving care while you are a bed patient in a hospital or skilled nursing facility.
In-network doctor	is a network of providers and facilities that have agreed to accept Anthem's allowable charge as payment in full for their services. When you receive care from an in network doctor and facilities you won't be charged for any outstanding balances beyond your co-payment and coinsurance amount for covered services.
Outpatient	refers to a person receiving care in a hospital outpatient department, emergency room, professional provider's office, or your home
Out of pocket	the maximum of amount that you will pay each year. Once the limit on your health plan is reached, almost all other covered expenses are paid in full for the rest of the calendar year. Does not include cost of prescription drugs, or vision benefits
Pre and Post Natal care	pre and post natal care for pregnancy
Primary care physician ("PCP") under the HMO Plan	is the HMO physician you must select to provide primary health care and to coordinate services you may require. PCPs specialize in the areas of general practice, family practice, internal medicine, and pediatrics.
<u>What is a HMO?</u> *HealthKeepers 25/1000*	Requires the selection of a Primary Care Physician (PCP) who will coordinate all of the member's care. When accessing care from a provider other than the member's PCP, HealthKeepers members must attain a referral from their PCP.
HealthKeepers 25/1000	*There is no referral requirement under the HealthKeepers 25/1000*
<u>What is a HSA Lumenos Plan?</u> *(Health Savings Account)*	Utilizes the PPO network and there are no referrals required. May open a Health Savings Account where the funds may be used at anytime for medical expenses.

06.01.2011

Anthem HealthKeepers 25/1000 Open Access

Covered Services		You Pay
Preventive Care Services		
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.		*** No charge**
Routine Vision		
o annual routine eye exam		**$15** for each visit
Spinal Manipulation		
o spinal manipulation and manual medical therapy services (chiropractic care) ***Limited to 30 visits per plan year.***		**$25** for each visit
All Other Services		
You will pay all the costs associated with your care until you have paid $1,000 in one plan year. This is known as your deductible. o If two people are covered under your plan, each of you will pay the first $1,000 of the cost of your care ($2,000 total). o If three or more people are covered under your plan, together you will pay the first $2,000 of the cost of your care. However, the most one family member will pay is $1,000. **Once you reach your deductible you pay:**		
Doctor Visits		
o office visits o home visits o urgent care visits	o in-office surgery o voluntary family planning	**$25** for each visit to your PCP **$50** for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests		
o diagnostic x-rays o lab work ****A copay does not apply when these services are provided by the same provider on the same day as the office visit.***	o other diagnostic test	**$25** for each visit to your PCP* **$50** for each visit to a specialist*
o advanced diagnostic imaging services ****Your payment responsibility is waived if services are billed as a part of an emergency room visit.***		**$150** for each visit*
Other Outpatient Services		
o hospice services o insulin pumps and oxygen	o durable medical equipment o partial day mental health and substance abuse services	**No Charge**
o ambulance travel		**$100** per transport
o home health care services		**$50** per plan month

SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.

For benefits listed with specific limits all services received during the plan year from October 1 through September 30 for that benefit are applied to that limit (whether received in or out-of-network). Your deductible amount begins anew on October 1 each year.

00986VAMEN Rev. 7/09

HealthKeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Covered Services	You Pay
Other Outpatient Services (continued)	
o prosthetic devices o injectable medications* (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office) ***You will also pay an additional $25 or $50 office visit copayment depending on the type of provider who treats you.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Therapy Services	
o occupational therapy** o speech therapy** o physical therapy** *****Limited to 30 combined visits per plan year for physical therapy and occupational therapy services, and 30 visits per plan year for speech therapy services.***	**$25** for each visit
o chemotherapy, radiation, cardiac and respiratory therapy	**$50** for each visit
o dialysis	**$50** per calendar month
Outpatient Infusion Services	
o facility	**$50** for each visit
o ambulatory Infusion Centers	**$50** per calendar month for IV services
o home services	**$50** per calendar month for IV services
Outpatient Surgery in a Hospital or Facility	
o surgery* ***Preventive care services are not subject to the deductible.***	**$150** for each visit
Inpatient Stays in a Hospital or Facility	
o skilled nursing facility (100 days for each admission)	**20%** of the amount health care professionals in our network have agreed to accept for their services
o semi-private room o private room when approved in advance o intensive or coronary care unit	**$300** per day (not to exceed **$1,500**) for an admission
Maternity	
o all routine outpatient pre- and postnatal care (excluding inpatient stays)	**$300** per pregnancy
o diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures)	**$50** for each visit
Outpatient Mental Health and Substance Abuse	
o medication management o individual therapy up to 30 minutes in length o group therapy	**$20** for each visit
o other mental health and substance abuse visits	**$30** for each visit
Emergency Care and Out of the Service Area Urgent Care	
o urgent care visits	**$50** for each visit
o true emergency care visits in our out of the service area ***Waived if admitted directly to the hospital.***	**$250** for each visit to an emergency room*
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
o diagnosis and treatment of autism spectrum disorder including: 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.
o applied behavioral analysis o limited to a $35,000 per member annual maximum	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth through age 2	
o limited to a $5,000 per member annual maximum* ***Unlimited physical, occupational and speech therapy***	Member cost shares will be dependent on the services rendered.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Plan Year (October 1 – September 30)

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 the covered services outlined in this insert is $0, except for services listed below.

- 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 following do not count toward the plan year out-of-pocket maximum. You will still need to pay:

- the costs associated with vision benefits
- the cost of prescription drugs
- the cost of dental benefits
- the cost of care received when the benefit limits have been reached

Some benefits may be subject to balance billing, if provided by a non-participating provider. For more information on balance billing, see the enrollment brochure.

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.

10.01.2012 bcr 07.13.2012

Your prescription drug benefits

Pharmacy network

Our prescription drug program manages more than 400 million prescriptions each year. With a broad retail pharmacy network, home delivery and a specialty unit that dispenses high-cost, biotech therapies, our comprehensive approach helps you manage your pharmacy benefits.

Some members have a tiered drug list/formulary, or list of covered medications, which assigns drugs to specific tiers based on cost. Tier 1 drugs have the most affordable copay. Tier 2 drugs cost slightly more, and Tier 3 drugs have the highest copay amounts.

Under your plan, for third-tier drugs you'll pay the greater of the third-tier copayment or 20 percent coinsurance with a $200 or $400 per-prescription maximum. There will also be a $3,500 per member per calendar year out-of-pocket maximum included with this benefit.

Your Prescription Drug 10-30-50 or 20% Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	$10	$30	The greater of $50 or 20% coinsurance with a $200 prescription maximum
Up to a 90-day medication supply delivered to your home	$10	$60	The greater of $150 or 20% coinsurance with a $400 prescription maximum

Retail pharmacies

Our retail pharmacy network includes more than 62,000 pharmacies throughout the United States. That means you have convenient access to your prescriptions wherever you are – at home, work or even on vacation. To find out if your pharmacy participates in our network, contact Customer Care at the phone number listed on your member ID card. Or, visit **anthem.com** for a list of participating pharmacies.

Most plans allow you to get up to a 30-day supply of covered medications at a retail pharmacy. Simply show your ID card at the pharmacy and pay the appropriate copay.

You'll get the most from your benefits by using a participating retail pharmacy. Choosing a non-network pharmacy means you'll pay the full cost of the prescription. Then, you must submit a claim form to our pharmacy program for reimbursement, based on your benefit.

Home delivery pharmacy

Home delivery is for people who take medications on an ongoing basis. Our preferred home delivery pharmacy delivers the medications you need, right to your door. You can easily refill home delivery prescriptions by phone, fax, mail or online. And, view benefit information 24/7 at **anthem.com**.

As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Personal prescription counseling
- Direct access to licensed pharmacists

- Our 99.99 percent accuracy rate, plus multiple safety checks by licensed pharmacists
- Experienced Customer Care associates to answer benefit questions

Getting started with home delivery

Switching to home delivery is simple. Choose from one of the following methods:

- **By phone:** Call **866-281-4279**, Monday through Friday, 8:30 a.m. to 8 p.m., Eastern Standard Time, to get your free cost-savings estimate. You'll find out how much your prescription will cost and how much you'll save. We'll even contact your doctor for a new prescription and arrange for delivery. *Be sure to have the following information handy:* prescription information, doctor's name, phone number, medication names/strengths and credit card information (including cardholder name, account number and expiration date).

- **By mail:** To get an order form, call the Customer Care number on your member ID card. Or, download a form from **anthem.com**. Click on the "Members" tab, and you'll find a link to the form under *Members Spotlight*. Print the form and mail your completed order form, original prescription and payment information to:

  Home Delivery Pharmacy
  PO Box 66785
  St. Louis MO 63166-6785

- **By fax:** Have your doctor fax your prescription information to **800-600-8105**. The prescription must be faxed directly from your doctor's office. If there is a question about your prescription(s), we'll contact your doctor.

Ordering home delivery refills

With home delivery, you don't have to worry about running out of medication. That's because we'll call to let you know when you're running low. You can easily reorder by phone, online or by mail:

- **By phone:** Have your prescription label and credit card ready. Call **866-281-4279** and select the "Automated Refill Order Line" option from the menu, or press zero at any time to speak to a care coordinator. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

- **Online:** Go to **anthem.com**, log in and click on the "MyPharmacy" tab.

- **By mail:** Complete an order form and affix your label or write the prescription refill number in the area provided. Mail the order form with the proper payment to:

  Home Delivery Pharmacy
  PO Box 66785
  St. Louis MO 63166-6785

Specialty pharmacy

Specialty medications are the fastest growing segment of U.S. drug spending today. These breakthrough biotech drugs are revolutionizing care for people with these medication needs. Our specialty pharmacy

offers a robust, personalized support program for people with chronic and complex conditions. These conditions may include but aren't limited to:

- Alpha[1] antitrypsin deficiency
- Asthma
- Cancer
- Crohn's Disease
- Gaucher's Disease
- Hemophilia
- Hepatitis C
- HIV/AIDS
- Infertility
- Multiple sclerosis
- Primary immune deficiency
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Our pharmacy care advocates, registered nurses and clinical pharmacists work together to provide disease-specific care management. We'll coordinate specialty pharmacy activities to help improve the quality and cost of care. And we'll do everything we can to help you achieve the best possible outcomes from your treatments.

Ordering specialty medications
You can order specialty medications by phone or fax:

- **By phone:** Call **800-870-6419** to verify your information. Pharmacy care advocates are available Monday through Friday, 8 a.m. to 10 p.m., Eastern Standard Time.

- **By fax:** You can have your doctor fax your prescription(s) and a copy of your ID card to **800-824-2642**.

Drug list/formulary

Our drug list/formulary is a list of brand and generic medications that are approved by the U.S. Food and Drug Administration (FDA) and covered by your plan. We're committed to providing you with access to quality medications at a price you can afford. Through detailed research, we find drugs with the highest success rates that also help lower the cost of care.

Our Pharmacy and Therapeutics (P&T) Committee then reviews and selects these medications for their safety, effectiveness and value. The P&T Committee includes a large group of doctors and pharmacists who are not employees of Anthem Blue Cross and Blue Shield. This group and other professionals are responsible for the decisions surrounding our drug list/formulary.

Medications on the drug list/formulary are subject to periodic review. Log in to **anthem.com** to view the most current list or call the phone number on your member ID card to check a specific drug.

Generic medications

Our drug list/formulary includes money-saving generics, as well as brand medications. By choosing a generic, you get the same effect as the brand drug – but normally at a lower cost.

Generic and brand drugs have the same active ingredient, strength and dose. The FDA requires generics to meet the same high standards for purity, quality, safety and strength.

Even though the active ingredient of a generic is identical to its brand counterpart, manufacturers may use different inactive ingredients. This could affect the color, shape and size. But because generics must meet the same FDA standards as brand drugs, you can feel confident the generic is just as safe and effective. Ask your doctor if a generic is right for you.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need our review and approval before they're covered. This process, called prior authorization, helps ensure drugs are used as recommended by the FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost you less
- Restrictions for use with very specific conditions

If your doctor prescribes a drug that requires prior authorization, we'll send an electronic notice to your pharmacy. This lets the pharmacist know that additional health information is needed for review.

By monitoring the use of certain drugs, prior authorization helps keep you safe and make your medications affordable. To check if your medication requires prior authorization, visit **anthem.com** or call the number on your member ID card.

HealthKeepers, Inc. 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.

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Anthem. HealthKeepers

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
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	You Pay: $50
Bifocal	You Pay: $70
Trifocal	You Pay: $105
Eyeglass Lens Options/Upgrades* – For those who like to add an extra touch to their eyewear!	
UV Coating	You Pay: $15
Tint (Solid and Gradient)	You Pay: $15
Standard Scratch-Resistance	You Pay: $15
Standard Polycarbonate	You Pay: $40
Standard Progressive (Add-on to bifocal)	You Pay: $65
Standard Anti-Reflective Coating	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.

This benefit overview insert is only one piece of your entire enrollment package. Exclusions and limitations are listed in the enrollment brochure.

Offered by HealthKeepers,Inc.,Peninsula Health Care, Inc., and Priority Health Care, Inc. Independent licensees of the Blue Cross and Blue Shield Association. Anthem HealthKeepers and Blue View Vision are registered marks of the Blue Cross and Blue Shield Association.

Your Summary of Benefits: CULPEPER COUNTY & SCHOOLS
Effective Date: 10/1/2012
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!

This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

Dental coverage you can count on

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.

You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE		In-Network	Out-of-Network
Annual Benefit Maximum	Plan Year		
• Per insured person		**$1,000**	**$1,000**
Annual Maximum Carryover		**No**	**No**
Orthodontic Lifetime Benefit Maximum			
• Per eligible insured person		**N/A**	**N/A**
Annual Deductible			
• Per insured person		**$0**	**$0**
• Family maximum		**No Limit**	**No Limit**
Deductible Waived for Diagnostic/Preventive Services		**Yes**	**Yes**
Out-of-Network Reimbursement Options:		**90th percentile**	
Dental Sevices		In-Network Anthem Pays:	Out-of-Network Anthem Pays:
Diagnostic and Preventive Services, for example:		100% Coinsurance	100% Coinsurance
• Periodic oral exam			
• Teeth cleaning (prophylaxis)			
• Bitewing X-rays: 1x per plan year			
• Intraoral X-rays			
Basic Services		Not Covered	Not Covered
Fillings, for example:			
• Amalgam (silver-colored)			
• Front composite (tooth-colored)			
• Back composite, Alternated to Amalgam Benefit			
Basic or Major Services			
Crowns		Not Covered	Not Covered
Prosthodontics, for example:		Not Covered	Not Covered
• Dentures			
• Bridges			
• Dental implants Not Covered			
Prosthetic Repairs/Adjustments		Not Covered	Not Covered
Endodontics, for example:		Not Covered	Not Covered
• Root Canal			
Periodontics, for example:		Not Covered	Not Covered
• Scaling and root planing			
Oral Surgery		Not Covered	Not Covered
Waiting Period for Basic Services:	No Waiting Periods		
Waiting Period for Major Services:	No Waiting Periods		
Orthodontic Services			
·None		Not Covered	Not Covered
Waiting Period: N/A			

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

VA_PCLG_FI-Custom

Emergency dental treatment for the international traveler
As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.**
With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

Finding a dentist is easy.
To select a dentist by name or location, do one of the following:
• Go to anthem.com/mydentalvision
• Call Anthem dental Customer Service at 866-956-8607

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Plan Year

Teeth cleaning (prophylaxis) Limited to two per Plan Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Coverage Every 3 Years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services. Please see your dental proposal page to determine your coverage.

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Crowns Limited to once per tooth in a seven-year period

Fixed or removable prosthodontics – dentures, partials, bridges

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

Brushed Biopsy Not Covered

*****Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage

Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions Surgical removal of asymptomatic, nonpathologic third molars

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Anthem BCBS is the trade name for Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed amounts
For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges $1,200 for the service and bills Anthem for that amount.
Anthem's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

Your Summary of Benefits: CULPEPER COUNTY & SCHOOLS
Effective Date: 10/1/2012
Anthem Dental Complete

WELCOME TO YOUR DENTAL PLAN!

This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

Dental coverage you can count on

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

Savings beyond your dental plan benefits - you get more for your money.

You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

YOUR DENTAL PLAN AT A GLANCE		In-Network	Out-of-Network
Annual Benefit Maximum • Per insured person	Plan Year	**$1,000**	**$1,000**
Annual Maximum Carryover		**No**	**No**
Orthodontic Lifetime Benefit Maximum • Per eligible insured person		**N/A**	**N/A**
Annual Deductible • Per insured person • Family maximum		**$50** **3X Individual**	**$50** **3X Individual**
Deductible Waived for Diagnostic/Preventive Services		**Yes**	**Yes**
Out-of-Network Reimbursement Options:		**90th percentile**	
Dental Sevices		In-Network Anthem Pays:	Out-of-Network Anthem Pays:
Diagnostic and Preventive Services, for example: • Periodic oral exam • Teeth cleaning (prophylaxis) • Bitewing X-rays: 1x per plan year • Intraoral X-rays		100% Coinsurance	100% Coinsurance
Basic Services **Fillings, for example:** • Amalgam (silver-colored) • Front composite (tooth-colored) • Back composite, Covered as Composites		80% Coinsurance	80% Coinsurance
Basic or Major Services			
Crowns		50% Coinsurance	50% Coinsurance
Prosthodontics, for example: • Dentures • Bridges • Dental implants Not Covered		50% Coinsurance	50% Coinsurance
Prosthetic Repairs/Adjustments		50% Coinsurance	50% Coinsurance
Endodontics, for example: • Root Canal		80% Coinsurance	80% Coinsurance
Periodontics, for example: • Scaling and root planing		80% Coinsurance	80% Coinsurance
Oral Surgery		80% Coinsurance	80% Coinsurance
Waiting Period for Basic Services:	No Waiting Periods		
Waiting Period for Major Services:	No Waiting Periods		
Orthodontic Services ·None **Waiting Period:** N/A		Not Covered	Not Covered

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

VA_PCLG_FI-Custom

Emergency dental treatment for the international traveler

As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.** With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

Finding a dentist is easy.

To select a dentist by name or location, do one of the following:

- Go to anthem.com/mydentalvision
- Call Anthem dental Customer Service at 866-956-8607

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system.	Refer to the back of your plan ID card for the address.

Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

Diagnostic and Preventive Services

Oral evaluations (exam) Limited to two per Plan Year

Teeth cleaning (prophylaxis) Limited to two per Plan Year

Intraoral X-rays, single film Limited to four films per 12-month period

Complete series X-rays (panoramic or full-mouth) Coverage Every 3 Years

Topical fluoride application Limited to once every 12 months for members through age 18

Sealants Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services. Please see your dental proposal page to determine your coverage.

Space Maintainers Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16

Basic and/or Major Services***

Fillings Limited to once per surface per tooth in any 24 months

Crowns Limited to once per tooth in a five-year period

Fixed or removable prosthodontics – dentures, partials, bridges

Covered once in any five-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is five years old or older and cannot be made serviceable.

Root canal therapy Limited to once per lifetime per tooth; coverage is for permanent teeth only.

Periodontal surgery Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

Periodontal scaling and root planing Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

Brushed Biopsy Not Covered

*****Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There may be a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.

Services provided before or after the term of this coverage

Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) Orthodontic braces, appliances and all related services

Cosmetic dentistry Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Extractions Surgical removal of asymptomatic, nonpathologic third molars

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

Anthem BCBS is the trade name for Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

Choice of dentists
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

Here's why:

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

How Anthem dental decides on maximum allowed amounts
For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

Here's an example of higher costs for out-of-network dental services
This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges $1,200 for the service and bills Anthem for that amount.
Anthem's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

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

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)

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

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.

20619VAMENBVA 4/11

Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, if you have an urgent or emergency medical situation, rest assured your coverage travels with you. The BlueCard® program makes sure of that by uniting Anthem HealthKeepers' 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 HealthKeepers 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 HealthKeepers 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.

12663VAMEN Rev. 6/10

Your prescription drug plan

Retail pharmacy network

Our network includes more than 56,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

To make sure your pharmacy's in our network, visit **anthem.com**.

- Log in and click on "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left-hand column.
- Click on "Find a Pharmacy."

Choosing a non-network pharmacy means you'll pay the full cost of your drug. Then, you may submit a claim form to be repaid. To access the form, visit **anthem.com**.

- Log in and select the "Refill a Prescription" link. You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left-hand column, then click on "Coverage & Copayments." The claim form is on this page.

Home Delivery Pharmacy

Home delivery is for people who take medicine on an ongoing basis. Our preferred home delivery pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Note about your pharmacy information on the web:

Express Scripts is the company that manages the operations of your drug plan. The first time you're directed to the Express Scripts website, you'll go through a brief registration. The purpose is to set your preferences for communication and privacy. You'll do this only once.

Please do not go directly to the Express Scripts website. The only way to make sure you're viewing your pharmacy information correctly is by logging in to **anthem.com** first.

13127VAMENABS Rev. 2/12

Your prescription drug plan (continued)

Getting started with home delivery

Switching is simple. You can order by mail or fax. Your order should arrive within 14 days of the date we receive your order form.

By mail: Visit **anthem.com** to get an order form.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "Fill a New Prescription."
- Choose the "Print a Prescription Order Form" link. You can print the form and complete it by hand. Or you can fill out a web-based form and print it.
- Mail your completed form, prescription from your doctor for a 90-day supply, and payment to:

  Home Delivery Pharmacy
  PO Box 66785
  St. Louis, MO 63166-6785

By fax: Have your doctor fax your prescription and plan ID card to **800-600-8105**. It must be faxed directly from your doctor's office. If there is a question about your prescription, the pharmacy will contact your doctor.

Ordering refills

With home delivery, you don't have to worry about running out of medicine. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

By phone: Have your prescription label and credit card ready. You can order whenever you like, 24/7. Call **866-281-4279** and select "Automated Refill Order Line" from the menu. Or press zero any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

By mail: Fill out an order form you received with a previous order. Affix your label or write your refill number in the space provided. Mail the form and your payment to:

Home Delivery Pharmacy
PO Box 66785
St. Louis, MO 63166-6785

Your prescription drug plan (continued)

Online: Visit **anthem.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click "Place My Order."

Specialty pharmacy

CuraScript, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. They include (but aren't limited to):

- Asthma
- Bleeding disorders
- Cancer
- Crohn's disease
- Cystic fibrosis
- Growth hormone deficiency
- Hepatitis
- HIV/AIDS
- Iron overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments.

CuraScript's CareLogic© programs help people with the conditions listed on this page. These programs teach you about treatment for your condition and help you understand and cope with medication side effects. CareLogic nurses and pharmacists will schedule time with you to find out how you are doing. They also will help you manage the side effects of treatment.

Call 888-773-7376, Monday through Friday, 8 a.m. to 9 p.m., Eastern time, to learn about how CareLogic can help you better manage your health condition.

Your prescription drug plan (continued)

Ordering specialty drugs

You can place your first order by phone or fax.

By phone: Call **800-870-6419**, Monday through Friday, 8:00 a.m. to 10:00 p.m.; Saturday, 9:00 a.m. to 1:00 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your plan ID card to **800-824-2642**.

Ordering refills

Online: Visit **anthem.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click "Place My Order."

Note: For some drugs, you must call to order a refill.

By phone: Have your member ID number and CuraScript prescription number ready. Call **800-870-6419**, Monday through Friday, 8:00 a.m. to 10:00 p.m.; Saturday, 9:00 a.m. to 1:00 p.m., Eastern time, and select "Place a Refill Order" from the menu. Or press zero any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-221-6915**. Follow the prompts to place your order.

Drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs.

We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the drug list if new drugs come to market, or if new research becomes available. To view the current list, visit **anthem.com**. Click on "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the drug list on this page.

If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Your prescription drug plan (continued)

Generic drugs

If you're taking a brand-name drug, you may save money by switching to an effective, lower-cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, your drug will work just as well as a brand drug – but usually at a lower cost.

Brand and generic drugs have the same active ingredient, strength and dose. And, generics must meet the same high standards for safety, quality and purity.

Why generics cost less

Developing a new drug is expensive. When a company creates a new drug, it gets a patent for up to 20 years. That means only the company that created it can sell it during that time. Once the patent expires, other companies can make copies of the same drug. These companies can avoid the high costs of developing the drug – and that helps lower the price for you.

Talk to your doctor to see if a generic is right for you. Don't switch or stop taking any drugs until you talk to your doctor.

Prior authorization

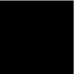
Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less
- Rules for use with very specific conditions

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

The drug list also includes this information. To view it, visit **anthem.com**. Click on "Customer Care" in the top-right corner. Select your state, then click on "Download Forms." You'll find the drug list on this page.

EXPRESS SCRIPTS®



HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:

1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   PO Box 66785
   St. Louis MO 63166-6785

To FAX your prescription:

1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: ____________________

First Name: ____________ Last Name: ____________

Date of Birth: ____________ Phone: ____________

Address: ____________________

____

____

E-mail: ____________________

Allergies: ____________________

____

Health Conditions: ____________________

____

____

Over-the-Counter Medications: ____________

____

DOCTOR/PRESCRIBER

DEA: ____________________

Name: ____________________

Address: ____________________

____

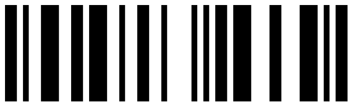
Phone: ____________________

Fax: ____________________

PATIENT OPTIONS

- ☐ I want non-child resistant caps, when available.
- ☐ I want a copy of my bottle label in large print on a separate sheet of paper.
- ☐ Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for $21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.



Rx

____________ ____________ **Date:** __ __ / __ __ / __ __

First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X ____________________
Doctor/Prescriber Signature – Substitution Permissible

X ____________________
Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

Important Confidentiality Notice: This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

© 2010 Express Scripts, Inc.

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 Anthem HealthKeepers coverage. Here are a few tips to keep in mind when seeking services.

Seeing a specialist

Your primary care physician may refer you to a specialist for additional care. In most cases, covered services need to be provided by network professionals. For specialty services you can coordinate yourself, you also need to use Anthem HealthKeepers network doctors, hospitals and other health care professionals or the services may not be covered. True emergency care services will be covered whether or not they are provided within the Anthem HealthKeepers network.

Referrals

Most referrals are for one or two visits. Primary care physicians can make referrals that last for a longer duration (called "standing referrals") to network doctors for members who need cancer pain management or have special conditions (typically life-threatening, degenerative or disabling conditions that require ongoing specialized attention).

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.

SERVICES COORDINATED FOR YOU

- **referrals for specialist visits**
- **standing referrals for special conditions**
- **advance authorization for hospital stays and outpatient surgery**
- **spinal manipulation and manual medical therapy services (chiropractic care)**

SERVICES YOU COORDINATE YOURSELF

- **routine, outpatient OB/GYN or nurse-midwife care**
- **maternity care**
- **mammograms**
- **outpatient mental health and substance abuse services**
- **certain outpatient oral surgery services or services used in conjunction with certain dental accidents**
- **emergency care**
- **urgent care services out of the service area**

The ins and outs of coverage

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

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

- who can be enrolled
- how coverage changes are handled
- what's not covered by your plan
- how your plan works with other coverage

Who can be enrolled

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

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

Coverage will end on the last day of the 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.

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 Anthem HealthKeepers 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 Anthem HealthKeepers 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.

00997VAMEN (04/12 for 03/12 benefits)

The ins and outs of coverage

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.

When you're covered by multiple plans

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

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

The ins and outs of coverage (continued)

Determining the primary versus secondary carrier

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

When a person is covered by 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	Anthem HealthKeepers	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

services not **authorized in advance** by us and pre-arranged by your primary care physician unless otherwise specific in this book

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 the HMO.

- 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.

The ins and outs of coverage (continued)

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

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

family planning

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

services for palliative or cosmetic **foot** care

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

Experimental ... or not?

Many of the Anthem HealthKepers 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.

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

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

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

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

home care services

- homemaker services (except as rendered as part of Hospice care)
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services

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

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

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 the HMO at its sole discretion. Notwithstanding this exclusion, all wellness services and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by Anthem HealthKeepers to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal the HMO's decision that a service is not medically necessary.

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 hospital
  - 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

services from **non-HMO** providers, except for emergencies when authorized in advance by the HMO Medical Director (this exclusion does not pertain to Point of Service plans or for an annual routine eye exam from an out-of-network provider)

The ins and outs of coverage (continued)

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.

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

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
- infertility medication
- 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

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

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

services or supplies or devices

- ordered by a doctor whose services are not covered under your health plan
- 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
- for injuries or illnesses incurred as a result of your commission of, or attempt to commit, a crime
- services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self
- benefits for charges from stand-by physicians in the absence of covered services being rendered
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies if provided or available to a member:

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

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

- amounts above the allowable charge for a service
- for which a charge is not usually made, including those not typically charged to members without coverage
- self-administered services or self care including self-administered injections
- self-help training
- 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

The ins and outs of coverage (continued)

sexual dysfunction surgery or sex transformation services, including medical and mental health services

services of non-HMO providers except for emergencies or when authorized in writing by our Medical Director including services not pre-arranged by your primary care physician and authorized in advance by us:

- women in at least their second trimester of pregnancy can continue to see their doctors who have left the Anthem HealthKeepers network, unless the doctors were asked to leave for cause
- members with a terminal illness who are expected to live less than six months can continue to see their doctors who have left the Anthem HealthKeepers network, unless the doctors were asked to leave for cause (this exclusion does not apply to Point of Service plans)

skilled nursing facility stays

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

smoking cessation programs not affiliated with us

spinal manipulation and manual medical therapy services (chiropractic care)

- any treatment or service not authorized by American Specialty Health Network, Inc. (ASHN)
- any service or treatment not provided by an ASHN provider (this exclusion does not apply to Point of Service plans) services for examination and/or treatment of strictly nonneuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment
- laboratory tests, x-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate or classified as experimental/investigative or in the research stage
- diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans and/or other types of diagnostic scanning, thermography
- educational programs, non-medical self-care and or self-help, or any self-help physical exercise training or
- any related diagnostic training
- air conditioners, air purifiers, therapeutic mattresses, supplied or any similar devices or appliances
- vitamins, mineral, nutritional supplements or any other similar type product

telemedicine

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

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

therapies

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

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

vision services

- 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 entity
- 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.

These services are not covered by your Anthem HealthKeepers plan.

Information You Should Know

13228WPMEN 4/10

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.

18004WPMENMUB 11/10

Your rights and responsibilities as an Anthem HealthKeepers member

As an Anthem HealthKeepers 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.
- Treat all doctors, health care professionals and staff with courtesy and respect.

Your rights and responsibilities as an Anthem HealthKeepers member (continued)

- 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".

20008ANMENABS 5/11

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

You've most likely 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. Here's a quick review of what the new law may mean to your group health plan. Keep in mind that other company plans may have different rules. If you have questions about your specific benefits, call the customer service number on your member ID card or ask your group benefits administrator for a number to call.

What's changed: When you join, you'll have a chance to add young adult children to your plan.

The federal health care reform law lets children (also called dependents) stay on their parent's or guardian's health plan until the end of the month when they turn 26 years old. In some states, they can stay on the plan even longer.

Children can be on your plan even if they are not:

- 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 children younger than 26 who aren't on your plan now and your company offers coverage for children, you can add them to your plan during your next open enrollment. If your plan already covers children up to age 26, you don't have to do anything. They'll stay on your plan automatically.

What's changed: Children under 19 can get coverage even if they have health problems.

The law says group health plans can't deny coverage to children under 19 if they have pre-existing conditions (health problems). Here's how a website run by the federal government, called healthcare.gov, defines a pre-existing condition: a pre-existing condition is "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 because of pre-existing conditions. But some plans still have waiting periods. A waiting period means that a child under 19 has to wait a certain amount of time before he or she can get covered for certain services.

17076MUMENMUB 5/11

Health care reform and your plan (continued)

What's changed: No more lifetime maximum dollar limits.

In the past, health 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. But 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. Check your Summary of Benefits to see if this applies to you.

What's new: You may have more choices in which doctors you can use.

This part of the law applies to you only if your plan says that you must choose a primary care provider (PCP) and get referrals from your PCP to see a specialist.

- If you have this type of plan (like an HMO), you can choose any PCP as your primary care doctor but the doctor has to be in our network, has to be accepting new patients and will accept you or your family members as patients.
- If your plan covers children, you may choose a pediatrician as their PCP.
- Also, you don't need a referral from your PCP or prior approval from your health care plan to see a gynecologist or obstetrician, as long as those doctors are in our network.

What's next? We'll keep you in the loop.

Things are going to keep on changing for a while. This notice only includes changes that may affect you within the next year. As things continue to change, we'll keep you up to date to make sure you get all the benefits that can help you and your family get and stay as healthy as possible.

17076MUMENMUB 5/11

Don't forget to click here to give us your feedback if you have not already done so.

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

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

Anthem. HealthKeepers
Offered by HealthKeepers, Inc.

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:

H-INTRO-HK (1/12), H-TOC (7/11), H-SB-HMO (7/11), H-SB-POS (3/12), H-SB LUM (3/12), H-WORKS-HK (3/12), H-COVERED-HK (3/12), H-EXCL (3/12), H-CLAIMS-HK (1/12), H-COB (7/10), H-ENR (10/10), H-ENDS (7/10), H–RIGHTS (7/09), H-DEF-HK (3/12), H-EXH-A (10/10), H-INDEX (7/10)

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

This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031

Life and Disability products underwritten by Anthem Life Insurance. HealthKeepers, Inc. is an independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

Visit us online at anthem.com