Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Your Anthem HealthKeepers

Catholic Diocese of Richmond
Lay Plan
Anthem HealthKeepers POS Open Access
Enrollment Guide
(Use HealthKeepers Participating Medical Providers)
Effective October 1, 2013

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

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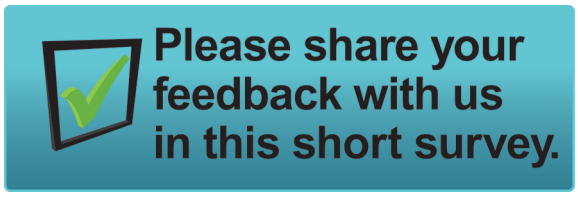
Please share your
feedback with us
in this short survey.

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Medical Benefits

Anthem HealthKeepers POS 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.

A primary doctor gives you the guided coverage of an HMO. Yet you can still go out-of-plan. That's flexible.

One, you have options. Anthem HealthKeepers POS is a Point-of-Service plan, which means you're free to choose doctors in or out-of-plan. This plan also includes an Open Access feature which allows you to seek specialist services without referrals. Of course, in-plan care will usually cost less than out-of-plan care. 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 POS Open Access at a glance

- *Primary Care Physicians (PCPs):* Flexible
  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. You can change your PCP as often as monthly, allowing you to "try on" different provider offices.
- *Referrals:* Not needed.
- *Claim Forms:* No claim forms to submit when using network providers.
- *Out-of-Plan Benefits:* Available for most services, but at more cost than when using in-plan providers. We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- *Out-of-Pocket:* This is the amount you'll pay, whether it is a straight copayment or some percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

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

12412VAMEN Rev. 3/12

Anthem HealthKeepers POS 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 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."

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Your Benefits

Anthem HealthKeepers

Anthem HealthKeepers 25/30 Point of Service Open Access Lay Plan

Your Anthem HealthKeepers Plan
Typically when you receive your care in a health care professional's office, you will pay a set fee as noted below. When services are received at a hospital or facility, you will pay 30% of the cost that the network hospital or facility has agreed to accept for their services.

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.	
o well-child visits o Pap tests o screening tests o immunizations o mammograms o Prostate Specific Antigen (PSA) test o checkups o prostate exams o gynecological exams *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.	**$25** for each visit to your PCP* **$50** for each visit to a specialist* **30%** for each visit to a hospital or facility*
Doctor Visits	
o office visits o in-office surgery o home visits o urgent care visits	**$25** for each visit to your PCP **$50** for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Test	
o diagnostic x-rays o lab work o diagnostic tests ***This fee is not required when these services are provided by the same professional on the same day as the office visit.***	**$25** for each visit to your PCP* **$50** for each visit to a specialist* **30%** for each visit to a hospital or facility
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* **30%** for each visit to a hospital or facility
Other Outpatient Services	
o hospice services o durable medical equipment o insulin pumps and oxygen	**No Charge**
o ambulance travel	**$100** per transport
o home health care services	**$50** per calendar month
o dialysis	**$50** per calendar month
o prosthetic devices	**30%** of the amount the health care professionals in our network have agreed to accept for their services
o injectable medication* (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

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit, whether received in or out-of-network.

Covered Services	You Pay
Therapy Service	
o occupational o physical o speech ***Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 visits per calendar year for speech therapy services. Services received in-plan and out-of-plan accumulate toward this limit.***	**$25** for each visit to a specialist's office **30%** for each visit to a hospital or facility
o chemotherapy o cardiac o radiation o respiratory	**$50** for each visit to a specialist's office **30%** for each visit to a hospital or facility
o spinal manipulation and manual medical therapy services ***Limited to 30 visits per calendar year. Services received in-plan and out-of-plan accumulate toward this limit.***	**$25** for each visit
Outpatient Infusion Services	
o facility	**30%** for each visit to a hospital or facility
o ambulatory infusion centers	**$50** per calendar month for IV services
o home services	**$50** per calendar month for IV services
Outpatient Surgery	
o surgery	**30%** for each visit to a hospital or facility
Inpatient Stays in a Hospital or Facility	
o semi-private room o private room when approved when approved in advance o intensive or coronary care unit o skilled nursing facility (100 days for each admission)	**30%** for each stay at a hospital or facility
Maternity	
o all routine pre- and postnatal care (excluding inpatient stays)	**$300** per pregnancy
o diagnostic tests o non-stress tests and other fetal monitor procedures o ultrasounds	**$50** for each visit to a specialist's office **30%** for each visit to a hospital or facility
Outpatient Mental Health and Substance Abuse Services	
o office visits	**$25** for each visit
o outpatient facility (including partial day treatment and intensive outpatient programs) o outpatient facility professional provider services	**No Charge**
Routine Vision	
o an annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit
Emergency Care and Out of the Service Area Urgent Care	
o urgent care visit	**$50** for each visit
o true emergency care visits in or out of the service area	**30%** for each visit to an emergency room

Out-of-Plan Services
Deductible for services received from out-of-plan health care professionals
You will pay all of the costs associated with covered services until you pay $1,000 in one calendar year. If two or more people are covered under your health plan, each member will be responsible for paying the first $1,000 toward covered services within a calendar year.
Once this amount has been reached, we will pay 70% of the amount doctors, hospitals and other health care professionals have agreed to accept for the same covered services.
If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $1,000 calendar year out-of-plan deductible) and you will pay the rest of what the professional charges.
In addition, you may seek spinal manipulation and manual medical therapy services (chiropractic care) from a provider not in our network without first meeting the out-of-plan deductible.

Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)
If you are the only one covered by your plan, you will pay $2,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. o If two people are covered under your plan, each of you will pay $2,500 ($5,000 total). o If three or more people are covered under your plan, together you will pay $5,000. However, no family member will pay more than $2,500 toward the limit. **The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:** o the costs associated with vision benefits o the cost of prescription drugs o the cost of dental benefits o 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.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

HealthKeepers, Inc. believes this plan is a ''grandfathered health plan'' under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to HealthKeepers, Inc. at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Autism Spectrum Disorder and Early Intervention

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

Covered Services	You Pay
Autism Spectrum Disorder (ASD) – For children from age 2 through 6	
Diagnosis of autism spectrum disorder; Treatment of autism spectrum disorder; o Behavioral Health Treatment* o Pharmacy Care o Psychiatric Care o Psychological Care o Therapeutic Care** * *Mental Health Services* ***Unlimited physical, occupational and speech therapy.*	Member cost shares will be dependent on the services rendered. Please refer to the Summary of Benefits.
Applied Behavioral Analysis o Limited to a $35,000 per member annual maximum.	30% after applicable deductible if any
Early Intervention – For children from birth through age 2	
o Limited to $5,000 per member annual maximum* **Unlimited physical, occupational and speech therapy*	Member cost shares will be dependent on the services rendered. Please refer to the Summary of Benefits.
Out-of-Network Services	
Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits	
If your plan includes out-of-network benefits and you receive covered services from a health care provider outside of our network, the out-of-network deductible and coinsurance applies as outlined in the Summary of Benefits.	

Anthem

And Its Affiliate HealthKeepers, Inc.

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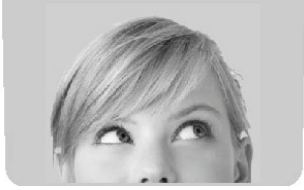
WELCOME TO BLUE VIEW VISION!

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



Blue View Vision℠ Exam Only A15 Plan

Anthem HealthKeepers

Your Blue View Vision network

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

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam (once every calendar year)	$15 copay, then covered in full	$30 allowance
Retinal Imaging - ***at member's option can be performed at time of eye exam***	Discounted member cost up to $39	Discount not available

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.

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. Just visit a participating Blue View Vision eye care professional or vision center and enjoy 35% off the retail price* of eye glass frames and 15% off the retail price of conventional (non-disposable) contact lenses. You can also save 20% off the retail price of non-prescription sunglasses and eye care accessories. Plus you'll get special member savings* on standard eyeglass lenses, lens treatment options and upgrades. Restrictions may apply and discounts are subject to change without notice.

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

OUT-OF-NETWORK

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 your eye exam and you pay the rest. In-network benefits and discounts will not apply. When visiting an out-of-network provider, you are responsible for payment of services at the time of service. If you choose an out-of-network provider, please complete the out-of-network claim form and submit it along with your itemized receipt via any of the following methods:

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

EXCLUSIONS & LIMITATIONS

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

Combined Offers. Not combined with any offer, coupon, or in-store advertisement.
Experimental or Investigative. Any experimental or investigative services.
Uninsured. Services received before insured person's effective date or after coverage ends.
Excess Amounts. Any amounts in excess of covered vision expense.
Eyewear. Any type of eyewear and related materials including eyeglass lenses, frames, or contact lenses.
Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment.
Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.
Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free.
Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage.
Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
Hospital Care. Inpatient or outpatient hospital vision care.
Orthoptics. Orthoptics or vision training and any associated supplemental testing.
Crime or Nuclear Energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available.

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

Your prescription drug plan

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

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 benefit year out-of-pocket maximum included with this benefit.

Retail pharmacy network

Our network includes more than 64,000 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.

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.

To access your pharmacy information, log on to **anthem.com**.

Home Delivery Pharmacy

Home delivery is for people who take medications 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

Your prescription drug plan (continued)

Getting started with home delivery

Switching is simple. You can order by phone, mail or fax.
By phone: Call **866-281-4279**, Monday through Friday, 8:30 a.m. to 8 p.m., Eastern time. You'll find out how much your prescription will cost and how much you can save. Have this information handy*: your* prescription, doctor's name, phone number, drug names and strengths and credit card information (including cardholder name, account number and expiration date).

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, and payments 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**. 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 medication. 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. Call **866-281-4279** and select "Automated Refill Order Line" option from the menu. Or press zero at 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 the prescription refill number in the space provided. Mail the order form with the proper payment to:

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

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 are not limited to):

- Asthma
- Cancer
- Crohn's Disease

Your prescription drug plan (continued)

- Gaucher's Disease
- Hemophilia
- Hepatitis C
- HIV/AIDS
- Multiple sclerosis
- Primary immune deficiency
- 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.

Ordering specialty drugs

You can place your first order by phone or fax:
By phone: Call **800-870-6419,** Monday through Friday, 8 a.m. to 10 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 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.

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. Selet 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.

Generic drugs

Your plan covers brand and generic (or non-brand) drugs. When you choose a generic, you'll get the same effect 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.

Your prescription drug plan (continued)

Prescription drugs will always be dispensed as ordered by your physician. If you or your doctor requests a brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

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 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.

Anthem Blue Cross and its HMO affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. 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.

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Prescription Program

Drug List / Formulary

Anthem Health. Join In.

QUESTIONS & ANSWERS

Q. ***What is a Drug List?***

A. The Anthem Drug List, also called a formulary is a list of U.S. Food and Drug Administration (FDA)-approved brand-name and generic drugs that have been reviewed and recommended for their quality and how well they work. The review is done by the National Pharmacy and Therapeutics (P&T) Process. The P&T Process is performed by an independent group of practicing doctors and pharmacists in charge of the research and decisions surrounding our drug list. This group meets regularly to review new and existing drugs and they choose the top drugs for our list—based on their safety, how they work and their value.

Because the drugs on our list are reviewed from time to time, it's a good idea to check the list to find out if any drugs have been added or removed. You can do this by going to anthem.com.

Q. ***What is a brand-name drug?***

A. These are drugs that are developed by a company who holds the rights to sell them. When the rights expire, other drug companies can make their own version of the drugs (see generic drugs below). You may be more familiar with brand-name drugs through advertising or because you know people who take them.

Q. ***What is a generic drug?***

A. Generics are simply copies of brand-name drugs. Brand-name and generic drugs have the same active ingredients, strength and dose. And the FDA requires that generic drugs meet the same high standards for purity, quality, safety and strength. **With generics, you get the same quality for less money.**

Q. ***What if my doctor or I choose a brand-name drug when a generic version is available?***

A. In most cases, you would be responsible for the copay that's listed on the tier the drug is on. This copay may include an added charge for the cost difference between the brand-name medication and the generic version.

Q. ***What are "clinically equivalent" medications? How does this affect my drug coverage?***

A. When drugs are compared in studies, some drugs have been found to be just as effective as others. These drugs are called "clinically equivalent" so it means they work just as well. Part of the P&T Process is to review the most current studies to see if multiple drugs used to treat a disease or a condition have the same effect on a patient. When this is the case, the Process review team may suggest that we cover only the lower cost drug (so we can help keep the overall cost of care as low as possible). This means your specific drug plan may not cover some drugs (indicated by a ^ symbol next to the drug name) that have clinically equivalent options.

Q. ***What if my medication is not on the drug list?***

A. You may want to first check with your doctor about prescribing a drug that is on the drug list. If your doctor prescribes a drug that's not on the drug list, you will need to pay the copayment that applies to drugs that are not on the list.

Please contact the member services number on your ID card if you have questions.

Drug list effective as of April 1, 2012

Please use this quick reference list when you receive a prescription. To get the most from your prescription drug benefits, ask your doctor to prescribe a medication on the drug list. Remember, if a drug from the drug list is prescribed, your out-of-pocket expense could be less than if a medication not included on the drug list (Tier 3) is prescribed for you. Below is a partial listing of the Anthem drug list which is subject to periodic review.

Please ask your physician or call toll free 877-468-5279 to hear a recorded list of the most current drug list additions and deletions. TDD/TTY users, please call 800-221-6915. Or, view the drug list on our web site, anthem.com.

Please note that if a drug request is approved, it does not guarantee coverage. Some drugs, such as those used for cosmetic purposes, may be excluded from your benefits. Please refer to your insurance Certificate or Evidence of Coverage to know for sure.

MBNABROT-138 Rev. 04/12

Most Commonly Prescribed Medications from the Anthem Drug List

Tier 3: Brand (Tier 1 generics are available)

Accolate (zafirlukast)
Activella (estradiol/norethindrone) PA
Aceon (perindopril)
Acular, LS (ketorolac)
Aldara (imiquimod) QL
Allegra^ (fexofenadine) QL
Allegra-D^ (fexofenadine/PSE) QL
Alphagan, P (brimonidine)
Altace (ramipril)
Alupent (metaproterenol)
Amaryl (glimepiride)
Ambien, CR (zolpidem, ER) QL
Amerge (naratriptan) QL
Amoxil (amoxicillin)
Anaprox, DS (naproxen sodium, DS)
Ansaid (flurbiprofen)
Aricept (donepezil)
Astelin Nasal Spray (azelastine)
Atrovent (ipratropium bromide) QL
Augmentin, XR (amox/clav, XR) QL
Bactrim, DS (sulfamethoxazole/trimethoprim)
Betagan (levobunolol)
Biaxin, XL (clarithromycin, ER)
Caduet (amlodipine/atorvastatin) DO, QL
Calan, SR (verapamil, SR)
Capoten (captopril)
Carafate (sucralfate)
Cardizem, LA, SR, CD (diltiazem, LA, SR, CD) DO, QL LA, SR, CD only
Cardura (doxazosin)
Ceclor, CD (cefaclor, ER)
Ceftin (cefuroxime)
Cefzil (cefprozil)
Celexa (citalopram) QL
Climara (estradiol)
Cipro, XR (ciprofloxacin, ER) QL
Colazal (balsalazide)
Coreg (carvedilol)
Corgard (nadolol)
Cosopt (dorzolamide/timolol)
Cozaar (losartan) DO, QL
Crolom^ (cromolyn)
Cytotec (misoprostol)
Dalmane (flurazepam)
Desoxyn (methamphetamine)
Desyrel (trazodone)
Diabeta (glyburide)
Diflucan (fluconazole)
Dilacor XR (diltiazem CR) DO, QL
Ditropan (oxybutynin)
Dyazide (triamterene/HCTZ)
Effexor (velafaxine)
Effexor XR (venlafaxine er) DO, QL
Elestat^ (epinastine) QL
Estrace (estradiol)
Exelon (rivastigmine)
Famvir (famciclovir)
Fem HRT 1/5 (ethinyl estradiol/norethindrone)
Fibricor (fenofibric acid)
Flomax (tamsulosin)
Flonase (fluticasone) QL
Fosamax (alendronate) QL
Glucophage,XR (metformin, ER)
Glucotrol XL (glipizide XL)
Glucovance (glyburide/metformin)
Glynase Prestab (glyburide micro)
Halcion (triazolam)
Hydrodiuril (hydrochlorothiazide)
Hytrin (terazosin)
Hyzaar (losartan/hctz) DO, QL
Imdur (isosorbide mononitrate)
Imitrex tabs, nasal & inj (sumatriptan) QL
Inderal, LA (propranolol, LA)
Indocin, SR (indomethacin, SR)
Intal Soln. (cromolyn)
ISMO (isosorbide mononitrate)
Isoptin, SR (verapamil, SR)
Isordil (isosorbide dinitrate)
Kadian (morphine ER)
Keflex (cephalexin)
Kytril (granisetron) QL
Lamictal tablets & chewable (lamotrigine)
Lamisil (terbinafine) PA
Lasix (furosemide)
Levaquin (levofloxacin) QL
Lexapro (escitalopram) DO, QL
Lipitor^ (atorvastatin) DO, QL
Lodine, XR (etodolac, ER)
Lopid (gemfibrozil)
Lopressor, HCT (metoprolol, HCTZ)
Loprox gel & shampoo (ciclopirox)
Lortab (hydrocodone/APAP) QL
Lotensin, HCT (benazepril/HCTZ)
Lotrel (amlodipine/benazepril)
Lozol (indapamide)
Marinol (dronabinol)
Maxzide (triamterene/HCTZ)
Mevacor (lovastatin) DO, QL
Metaglip (glipizide/metformin)
Micronase (glyburide)
Mirapex (pramipexole)
Mobic (meloxicam) QL
Monoket (isosorbide mononitrate)
Motrin (ibuprofen)
Naprosyn (naproxen)
Nasacort AQ (triamcinolone acetonide) ST, QL
Nasarel (flunisolide) QL, ST
Neurontin (gabapentin)
Nitrostat (nitroglycerin)
Nizoral (ketoconazole)
Nolvadex (tamoxifen)
Norpramin (desipramine)
Norvasc (amlodipine) DO, QL
Ocupress (carteolol)
Ogen (estropipate)
Omnicef (cefdinir)
Omnipen (ampicillin)
Ortho-Est (estropipate)
Orudis (ketoprofen)
Oruvail (ketoprofen)
Pamelor (nortriptyline)
Paxil (paroxetine) DO, QL
Paxil CR (paroxetine sr) DO, QL
Periostat (doxycycline)
Persantine (dipyridamole)
Phoslo (calcium acetate)
Plan B 0.75mg (levonorgestrel) QL
Pravachol (pravastatin) DO, QL
Precose (acarbose)
Prevacid^ (lansoprazole) ST, QL
Prilosec^ (omeprazole) ST, QL
Prinivil (lisinopril)
Prinzide (lisinopril/hctz)
Proscar (finasteride)
Protonix^ (pantoprazole) ST, QL
Provera (medroxyprogesterone)
Prozac (fluoxetine) DO, QL
Pulmicort Respules (budesonide) 0.25mg/2ml, 0.5mg/2ml QL
Questran, Lite (cholestyramine, light)
Razadyne, ER (galantamine, SR)
Reglan (metoclopramide)
Remeron (mirtazapine)
Requip (ropinirole)
Restoril (temazepam)
Risperdal (risperidone)
Sanctura (trospium)
Septra, DS (sulfamethoxazole/trimethoprim)
Seroquel (quetiapine)
Skelaxin (metaxolone)
Sonata (zaleplon) ST, QL
Sporanox (itraconazole) PA
Starlix (nateglinide)
Sular (nisoldipine) DO, QL
Tagamet (cimetidine)
Tarka (trandolapril/verapamil)
Tenormin (atenolol)
Timoptic, XE (timolol, XE)
Tobradex (tobramycin/dexamethasone)
Tolectin (tolmetin)
Toprol XL (metoprolol succinate SR)
Trandate (labetalol)
Trental (pentoxifylline)
Tricor (fenofibrate)
Trileptal (oxcarbazepine)
Trinsicon (iron/intrinsicfx/B 12)
Trusopt (dorzolamide)
Ultram, ER (tramadol) QL
Univasc (moexipril)
Uniretic (moexipril/hctz)
Uroxatral (alfuzosin)
Vantin (cefpodoxime)
Verelan (verapamil SR)
Voltaren, XR (diclofenac, ER)
Wellbutrin, SR (bupropion, ER)
Wellbutrin XL (budeprion xl) DO, QL
Xalatan (latanoprost)
Xibrom (bromfenac soln)
Xopenex Neb. Soln 1.25/0.5 (levalbuterol)
Zantac (ranitidine)
Zaroxolyn (metolazone)
Zegerid^ (omeprazole/bicarb) ST, QL
Zithromax (azithromycin) QL
Zocor (simvastatin) DO, QL
Zofran (ondansetron) QL
Zoloft (sertraline) DO, QL
Zyprexa, Zydis (olanzapine, ODT)

Tier 2: Brand

Abilify
Actonel QL
ActoPlus Met, XR QL
Actos QL
Advair Diskus, HFA QL
Advicor DO
Akne-Mycin
Apriso
Asacol, HD
Astepro QL
Atrovent HFA QL
Avinza QL
Avodart
AzaSite
Azilect
Byetta ST, QL
Canasa
Ciprodex
Climara Pro
Colcrys
CombiPatch
Combivent QL
Coreg CR
Crestor DO, QL
Cymbalta QL
Depakote, ER
Detrol, LA
Diovan, HCT DO, QL
Dulera QL
Effient DO, QL
Estring
Evamist
Evista
Exforge, HCT QL
FemHRT0.5/2.5
Femtrace
Flovent, HFA QL
Fosrenol
Geodon
Glyset
Humalog
Humulin
Intal Inh.
Jalyn
Janumet QL
Januvia QL
Kombiglyze QL
Lanoxin
Lantus
Levemir
Lialda
Lidoderm
Lotemax
Lovaza†
Lumigan
Maxalt, MLT QL
Nasonex QL
Nexium QL
Niaspan
Nitro-Dur
Novolin
Novolog
Nuvigil PA, QL
Onglyza DO, QL
Pancrelipase
Perforomist
Pentasa
Plan B 1.5mg QL
Plavix† QL
Pradaxa QL
Prandin
Premarin
Premphase
Prempro
Pristiq QL
ProAir HFA QL
Prometrium
Proventil HFA QL
Pulmicort Respules 1mg/2ml QL
Renvela tab
Restasis
Retin-A Micro
Savella QL
Serevent Diskus QL
Seroquel XR
Singulair QL
Spiriva QL
Symbicort QL
Symbyax†
Symlin
Synthroid
Tegretol XR
Tekamlo DO, QL
Tekturna, HCT QL
Tilade
Toviaz
Trilipix
Ultrase
Uniphyl
Valturna DO, QL
Veltin
Veramyst QL
VESIcare
Vivelle Dot
Welchol
Xopenex Neb. Soln. (except 1.25/0.5ml)
Zenpep
Zylet

^ This product has clinically equivalent alternatives included on the formulary and, as a consequence, such product may not be covered under your pharmacy benefit. Please consult your online pharmacy account through your health plan web site, www.anthem.com, for details on coverage.

† A generic equivalent of this drug recently became available or will be available soon. After the generic drug becomes available and notification requirements are met, this brand-name drug will become non-formulary/Tier 3 or may no longer be covered by your prescription drug plan. Check anthem.com to find out about changes in formulary status.

PA PRIOR AUTHORIZATION REQUIRED – Prior authorization is the process of obtaining approval of benefits before certain prescriptions may be filled.

QL QUANTITY LIMITS – Certain prescription drugs have specific quantity limits per prescription or per month.

ST STEP THERAPY REQUIRED – You may need to use one medication before benefits for the use of another medication can be authorized. Please note: Foradil and Serevent are safety edits that prevent duplication of therapy.

DO DOSE OPTIMIZATION REQUIRED – Normally involves the conversion from twice-daily dosing to a once-daily dosing schedule.

Not all medications and not all plans are subject to prior authorization and quantity limits. For more information regarding prior authorization or quantity limits, contact Member Services at the telephone number listed on your identification card.

For Kentucky residents only: In selecting medications for the drug list, the therapeutic efficacy and cost effectiveness are addressed for each category. All therapeutic categories are represented on the drug list by at least one medication. When a closed drug list is in effect, only medications that are included on the drug list are a covered service. In certain clinical situations, a member may require use of a medication not included on the drug list (Tier 3). Anthem has criteria that permits a member to obtain a Tier 3 medication in a closed drug list plan. If specific criteria is met, the member can receive a Tier 3 drug for a drug list copay. The criteria preserves the clinical integrity of the drug list and provides a process by which deviations from the drug list may be allowed. There is a process to request a medication be added to the drug list for any medications that do not meet the criteria.

Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting the 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.
4. As an Anthem HealthKeepers Point of Service (POS) member, you are covered for office visits and other services at the same cost as out-of-network visits when you are at home.

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 HealthKeepers 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.

Ins and Outs of Coverage

Tips for understanding your coverage

(for Open Access, Point of Service or Value Advantage Plans)

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.

Services that require advance reviews

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

An explanation on how we define emergencies

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

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

Balance Billing

In some situations, such as an emergency, getting the care you need is the first priority. During these times, if you receive care from hospitals and/or providers who have not contracted with us, they can charge whatever they want for their services. If what they charge is more than providers in our network have agreed to accept for the same service, you can be billed for the difference. This is called "balance billing."

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.

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.

Dental Benefits

Dental Complete

Everyone wants a nice smile. But did you know taking care of your teeth and seeing your dentist for regular checkups can actually help protect your overall health? More than 90% of all diseases that impact your body produce signs and symptoms in your mouth.[1] Dental Complete can help you keep your smile bright and healthy.

HOW TO FIND A DENTAL PROVIDER

1. **Go to anthem.com/mydentalvision**
2. **Use the "Find Dental Providers" tool to search for dental providers in your area.**

Advantages of Dental Complete:

- **Your dentist is probably in the network.** In fact, you have access to more dentists and specialists than most other dental plans. To see if your dentist, orthodontist or periodontist is in our network, use the "Find Dental Providers" tool on anthem.com/mydentalvision.
- **Dental Complete covers a variety of services.** Whether you need a regular cleaning or filling, Dental Complete offers coverage. For details of what the plan covers, see the summary of benefits or talk to your benefits manager.
- **You get more for the money.** SpecialOffers@Anthem℠ offers discounts on wellness products and services, like fitness club memberships and LASIK eye surgery.[2]
- **You have access to worldwide dental emergency care.** Members traveling outside the U.S. have coverage for emergency dental services through a worldwide network of English-speaking dentists.[3]
- **The support you need.**
  - Visit anthem.com/mydentalvision for online services, forms, dental health tips and more.
  - Call our dedicated dental customer service line at the number on the back of your ID card.

1 Academy of General Dentistry website: Importance of Oral Health to Overall Health (October 2008): http://www.knowyourteeth.com/infobites/abc/article/?abc=0&iid=320&aid=1289.
2 Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for products, services, or information provided by these vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members.
3 The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Anthem Blue Cross and Blue Shield.

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WELCOME TO ANTHEM DENTAL!

This benefit summary outlines the basic components of your plan, providing you with a quick reference of your dental plan benefits. For complete coverage details, please refer to the plan certificate.

Anthem
Health. **Join In.**

Catholic Diocese of Richmond

Anthem Dental Passive PPO Complete Network

Effective Date 10/01/2012

Dental coverage you can count on.
Anthem dental lets you visit any licensed dentist or specialist you want—with costs that are normally lower when you choose one within the extensive network.

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

YOUR DENTAL PLAN AT-A-GLANCE

Annual Benefit Maximum – Calendar Year	**$1,250 per insured person**
Annual Deductible – Calendar Year (per insured person / family maximum)	**$50/$150**
Deductible Waived for Diagnostic and Preventive Services	**Yes**

DENTAL SERVICES Following are examples of what is/is not covered by your plan:	**IN-NETWORK** Anthem pays:	OUT-OF-NETWORK Anthem pays:
Diagnostic and Preventive Services, for example:	**100%**	100%
○ periodic oral evaluation (exam)		
○ prophylaxis (cleaning)		
○ bitewing X-rays		
○ intraoral X-rays		
○ sealants		
○ space maintainers		
Restorative Services, for example:		
Fillings	**80%**	80%
○ amalgam (silver colored) or composite (tooth colored)		
Endodontics	**80%**	80%
○ root canal		
Periodontics	**80%**	80%
○ scaling and root planing		
Oral Surgery	**80%**	80%
Prosthodontics	**50%**	50%
○ crowns		
○ dentures		
Orthodontic Services	**50%**	50%
○ coverage for Adults and children (age 8 and older)	**Adult and Child**	Same as in-network
○ ortho lifetime maximum benefits	**$1,250**	$1,250
Waiting Periods	**None**	None

Go to www.anthem.com/mydentalvision or call customer service to obtain an application for these benefits. 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 the dental certificate. In the event of a discrepancy between the information contained in this benefit summary and that in the dental certificate, the dental certificate will prevail.

VA-CUSTOM

In-network and out-of-network
Percentages shown in the benefits chart herein reflect the percentage of the Covered Expense that Anthem will pay.

Anthem Health. **Join In.**

Participating Providers are dentists who have contracted with us to provide dental care to our members at a negotiated rate. When using a participating dentist, you will only be responsible for your deductible and coinsurance amounts, if applicable.

Non-Participating Providers are dentists who have not contracted with us and therefore may charge their usual fee for services they provide to you. When using a non-participating dentist, you will be responsible for your deductible and coinsurance amounts, if applicable, plus any amount over our Covered Expense, up to the dentist's billed charges. While the percentage we pay is the same whether you receive dental services in-network or out-of-network, you may end up paying more out-of-pocket when you visit a non-participating provider.

TO CONTACT US:

Call	Write
Refer to the toll-free number indicated on the back of your plan identification card or call (866) 956-8607 to speak in-person 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 at (866) 956-8607.	Refer to the back of your plan identification card for the address.

Limitations & Exclusions

Limitations — Below is a partial listing of plan limitations. Please see your Certificate of Coverage for a full list.	Exclusions — Below is a partial listing of non-covered services. Please see your Certificate of Coverage for a full list.
Diagnostic and Preventive Services **Oral evaluations** (exam). Limited to two per Calendar Year. **Prophylaxis** (cleaning). Limited to two per Calendar Year. **Bitewing x-rays.** Limited to one series of films per 12-month period. **Intraoral x-rays, single film.** Limited to four films per 12-month period. **Complete series x-rays** (panoramic or full-mouth). Limited to once every 60 months. **Restorative Services – *applicable if these services are covered under your plan*** **Fillings.** Limited to once per surface per tooth in any 24 months. **Crowns.** Limited to once per tooth in a seven year period. **Fixed and removable prosthodontics – dentures, partials, and 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 5 millimeters or greater. **Periodontal scaling and root planing.** Limited to once per quadrant in 36 months when the tooth pocket has a depth of 4 millimeters or greater. **ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES –** **Orthodontia.** Limited to one course of treatment per member per lifetime.	**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 plan certificate. **Orthodontics (unless included as part of your plan benefits).** Orthodontic braces, appliances and all related services. **Cosmetic dentistry.** Any services performed for cosmetic purposes including, but not limited to, external bleaching, bleaching of non-vital discolored teeth, veneers. **Drugs and medications.** Intravenous conscious sedation, IV sedation and general anesthesia when performed with non-surgical dental care. Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services. **Extraction.** Surgical removal of asymptomatic, non-pathologic 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 and Blue Shield.

Health, Wellness & Anthem Advantages

Get the most out of your health plan

anthem.com

Clear. Intuitive. Easy.

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

Health and wellness

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

MyHealth Assessment
Your first step toward a healthier lifestyle

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

To use MyHealth Assessment:

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

MyHealth Record
Your health history in one secure location

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

To use MyHealth Record:

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

SpecialOffers
Discounts on health-related products and services

Get the most out of your health plan

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

To access all discounts:

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

Zagat® Health Survey
Doctor recommendations from your peers

Benefit from the experiences of fellow Anthem HealthKeepers members to help you find the doctor that's right for you. We've teamed with Zagat Survey, the world's most trusted source of recommendations by consumers, for consumers, to let you rate your doctors and see what others say about them.

To access the Zagat Health Survey:

- Log in at anthem.com
- Go to your Account Summary page to rate your Recently Visited Providers
- Under Customize your Summary, click/drag/drop "Recently Visited Doctors"
- See Zagat logo and link to "Rate this doctor"

Healthy Lifestyles
Support to help you achieve your goals

Lose weight, stop smoking, stress less and exercise more with our online tools and resources. Take advantage of online fitness tracking and customized workout plans, discounts on spa services and massage therapists, healthy recipes, smoking cessation programs and more. Plus, get the support you need at our online community forums.

To learn more:

- Log in at anthem.com
- Click on "Health & Wellness"
- Under "Healthy Lifestyles" select "Get Started"

Plans and benefits

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

Get the most out of your health plan

Anthem Care Comparison
Quality and cost information at your fingertips

Make informed decisions and save money by comparing actual costs for common procedures at hospitals and facilities in your area. In addition to price information, you can see procedure and quality comparisons that gauge performance and safety at each facility.

To use Anthem Care Comparison:

- Log in at anthem.com
- Go to your Account Summary page and select "Compare Facility Cost and Quality"
- Click/drag/drop "Compare Cost & Quality"
- Select "Compare Facility Cost & Quality"

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

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

To use Coverage Advisor:

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

Claims look-up
Easy access to claims information

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

To look up a claim:

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

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

Get the most out of your health plan

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

To search our online Provider Finder:

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

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

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

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

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

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

360° Health® programs

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

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

Take charge of your health and the choices you make

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

24/7 NurseLine

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

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

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

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

Future Moms

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

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

360° Health® programs

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

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

ConditionCare

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

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

ConditionCare Support Programs

If you or a family member is diagnosed with certain types of cancer, vascular or musculoskeletal diseases, or low back pain, ConditionCare may be able to help. It's a no-extra charge program that gives you toll-free, 24-hour access to Nurse Coaches — registered nurses who can help you better manage your condition and help you follow your physician's care plan. And it's all backed by a clinical team featuring pharmacists, dietitians and exercise physiologists. ConditionCare also gives you the information and tools that can help you avoid unnecessary doctor's office visits, hospitalizations, and time away from the job.

Ready to take more control of your health? Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

Here's how it works: We review your health status daily and check to see what medications you're taking. If we see that any of your medicines could interact with each other, we tell your doctor right away. We also keep track of when you need to get routine tests and checkups. We send you a reminder called a "MyHealth Note" when you should make these appointments. MyHealth Note has a summary of all your recent claims. And from time to time, we give you tips on how to save you money on your medications.

360° Health® programs

ComplexCare

ComplexCare is for our members with more than one health problem or a condition that puts them at risk for needing more care, more often. If you sign up for ComplexCare, you, your family and your doctors will work with a ComplexCare nurse and others on our staff. They'll help you meet health goals and help you avoid going in and out of the hospital.

With ComplexCare, you have 24/7 toll-free access to nurses who will work one-on-one with you to teach you about taking care of your condition while living the life you like to live. They'll also help you learn about why it's important to go for regular checkups and screenings. The nurses can help you make better choices about your care. They can also help make sure your doctors are all talking to each other about your care and what's best for you. If you qualify for the ComplexCare program, a nurse will contact you.

To learn more, log on to anthem.com or contact the customer service number on your ID card.

Healthy Lifestyles

Healthy Lifestyles is a free online program that gives you support and rewards to help you stay healthy or get healthier. Whether you want to quit smoking, lose weight, eat right, exercise more or manage stress, Healthy Lifestyles makes it easy to set goals, track your progress and earn rewards. With Healthy Lifestyles, you can:

- Sign up for a program to quit smoking
- Use nutrition and fitness trackers
- Find healthy recipes
- Join community and online forums
- Get discounts on massages, gym memberships, spa services and more

A healthier lifestyle can be just a mouse click away. To learn more, visit anthem.com.

Behavioral Health

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

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

360° Health® programs

Imaging Management

Our Imaging Management program works directly with your doctor to help you get the right imaging test – like an MRI or PET scan – for your needs. Getting the right test done the first time can mean a faster, more accurate diagnosis. It can also mean you're exposed to a smaller amount of radiation. And it can reduce the amount of money wasted on extra tests. The program gives your doctor's office a list of nearby imaging facilities that are in your health plan's network. And it even tells your doctor which one has the best quality and value for any given test. Please remind your doctor to contact our Imaging Management program whenever you need a test.

Information You Should Know

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

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

Utilization Management

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

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

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

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

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

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

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

Case Management

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

Your rights and responsibilities as an Anthem 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.

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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".

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Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

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

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

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

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

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

Your Protected Health Information

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

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

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

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

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your

dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

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

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

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

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

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

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

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

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

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

Potential Impact of Other Applicable Laws

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

Complaints

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

Contact Information

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

Copies and Changes

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

Important legal information you should take time to read

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

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

STATE NOTICE OF PRIVACY PRACTICES

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

Your Personal Information

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

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

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

Health care reform and your plan

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

Waiver of Group Health Benefits & Notice of Special Enrollment Rights

Catholic Diocese of Richmond

(Employer Name)

Please complete the following:

Employee Name: _____ _____ _____
(Last) (First) (MI)

Employee Number: _____
(Employee# or Social Security)

For the plan year effective ___/___/___ I am waiving coverage for:
(MM/DD/YY)

☐ Myself
☐ Spouse
☐ Dependent (s) – Please list names: _____

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's plan – name of carrier: _____

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS)
☐ Medicaid ☐ Employer-Sponsored Group Plan

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Signature of Employee Date of Signature

Return to your CDR Human Resources

Do Not Return to Anthem (AVA 1433)

Dental Membership Enrollment Form

Anthem
Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:	Last		First			Middle Initial		**Social Security Number** / /
Gender:	Male ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address					Home Phone Number		Work Phone Number
	City			State		Zip Code		

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		**Complete If Multiple Plan Options Are Offered**
☐ Employee Only*	☐ No Coverage*	I elect to participate in the following Plan:
☐ Employee and Spouse	* **If waiving coverage for employee and/or any eligible family members, you must complete Part D.**	☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D
☐ Employee and Dependent Child(ren)		
☐ Family		

PART C – DEPENDENT INFORMATION

Relationship To Employee	**First Name, Middle Initial, Last Name** (Include Last Name Only if Different From Employee's)	**Gender**		**Date of Birth** Month/Day/Year	**Full Time Student?**		**Unmarried?**	
Spouse		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

PART D – EMPLOYEE SIGNATURE – Select One

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No
Name of Carrier: _____ Policy/Identification Number: _____

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further dental enrollment changes.

Employee Signature: **Date:**

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. I have read, or have had read to me, the completed application and I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

Employee Signature: **Date:**

PART E – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Existing Anthem Dental Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date
Hire Date: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Open Enrollment**
Effective Date:
_____/_____/_____

☐ **Rehire** Date Lay Off Began: _____/_____/_____
Date Rehired: _____/_____/_____

☐ **Return from Leave of Absence**
Date Leave Began: _____/_____/_____
Date Returned to Work: _____/_____/_____

☐ **Employee Change Part Time to Full Time**
Date of Status Change: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Previously Waived Coverage or Loss of Coverage**
Qualifying Event Reason: _____
Hire Date: _____/_____/_____
Event Date: _____/_____/_____
Effective Date: _____/_____/_____

Group Name: **Group & Subgroup Numbers**:

Group Representative's Signature: **Date:** **Phone Number:** ( )

Employer Instructions

- Review Parts A, B, C, and D to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., first of month, end of month, or actual dates).

Employer Complete Part: E - Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer initial employee enrollment. Complete the Prior Coverage Start Date if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **Existing Dental Group** – Enrolling additional employees from an acquisition/merger who were not previously offered/enrolled in your dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **New Hire** – Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- **Open Enrollment** – An employee is enrolling during group's open enrollment period.
- **Rehire** – A former employee was rehired.
- **Return From Leave of Absence** – An employee is returning from leave of absence.
- **Employee Status Change** – The employee's employment status changed and the employee is now eligible for dental benefits.
- **Previously Waived Coverage or Loss of Coverage** – If an employee waives coverage; he/she can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage. If an employee or dependent involuntarily losses coverage and are now eligible to enroll, complete this section.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Forms To:
Anthem
Attention: Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193

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.

2161

Rx

_____ _____ **Date:** __ __ / __ __ / __ __

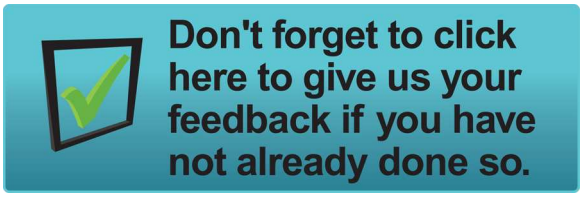
First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____ **X** _____

Doctor/Prescriber Signature – Substitution Permissible Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.


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)

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