



And Its Affiliate HealthKeepers, Inc.

# Benefits You Can Count On

KeyCare PPO

**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





# Your guide to benefits

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

## Explore the advantages of being an Anthem member.

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

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

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

- Go to [anthem.com](http://anthem.com)
- Click on Register
- Create your user name and password

Then you're ready to go!

## Your guide to benefits (continued)

### We're on Facebook, Twitter and YouTube.

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

- [Facebook.com/HealthJoinIn](https://www.facebook.com/HealthJoinIn)
- [Twitter.com/HealthJoinIn](https://twitter.com/HealthJoinIn)
- [YouTube.com/HealthJoinIn](https://www.youtube.com/HealthJoinIn)



Scan the code with your mobile capable device for a direct link to [anthem.com](https://www.anthem.com). Don't have a QR code reader? Download the free ScanLife app to your mobile device or visit [scanlife.com](https://www.scanlife.com).

# Ins and Outs of Coverage

## Important updates to your open enrollment brochure



Please note the following changes that have been made to the exclusions and limitations associated with your plan benefits. This information supersedes any out of-date information that was previously printed in the enrollment brochure.

Your benefits exclude services from **certain providers** that are not licensed by law to provide covered services. Example include but are not limited to masseurs or masseuses (massage therapists), physical therapist technicians and athletic trainers.

### Dental exclusion update

To create more consistency among our products, we've modified our dental exclusions as outlined below:

- a) Dental care for Members age 19 and over.
- b) Dental services not listed as covered in the brochure.
- c) Services of anesthesiologists, unless required by law.
- d) Intravenous and non-intravenous conscious sedation, analgesia and general anesthesia when given separate from a covered oral surgery service and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their professional to provide anesthesia services.
- e) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- f) Canal prep and fitting of preformed dowel and post.
- g) Temporary, provisional or interim crown.
- h) Occlusal procedures.
- i) Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- j) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- k) Case presentations.
- l) Athletic mouth guards, enamel microabrasion and odontoplasty.
- m) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- n) Bacteriologic tests for determination of periodontal disease or pathologic agents.
- o) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- p) Cytology sample collection – Collection of oral cytology sample via scraping of the oral mucosa.
- q) Separated services billed when they are an inherent component of another covered service.
- r) Pin retention is not covered when billed separately from restoration procedure.
- s) Services for the replacement of an existing partial denture with a bridge.
- t) Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials and bridges).
- u) Additional, elective or enhanced prosthodontic procedures including but not limited to: connector bar(s), stress breakers and precision attachments.
- v) Temporary procedures for interim stabilization.

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- w) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from restoration procedure.
- x) Pulp vitality tests.
- y) Adjunctive diagnostic tests.
- z) Analgesia, analgesia agents, anxiolysis nitrous oxide medicines or drugs for non-surgical or surgical dental care.
- aa) Incomplete root canals.
- bb) Cone beam images.
- cc) Anatomical crown exposure.
- dd) Temporary anchorage devices.
- ee) Sinus augmentation.
- ff) Oral hygiene instructions.
- gg) Repair or replacement of lost/broken appliances.
- hh) Removal of pulp debridement, pulp cap, post pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- ii) Root canal construction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

**Prescription exclusion update:**

Your benefits exclude coverage for **compound drugs** unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer.

Your benefits exclude coverage for **allergy services**, allergy desensitization products or allergy serum. While not covered under the prescription drug benefit at a retail or home delivery mail order pharmacy benefit, these items may be covered under the allergy services benefit.

This 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.

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# 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 children 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 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 coverage.

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

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

## The ins and outs of coverage (continued)

### Special enrollment periods

Typically you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is first offered to you as a "new hire" or during your employer's open enrollment period when employees can make changes to their benefits for an upcoming year. But there may be instances other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage. But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

### How we establish our rates

#### Factors used to set the price of health care coverage for employers with 2-99 employees:

- your employer's location
- age of each family member with one age band for members age 0 to 20, an age band for members age 21-63 and one age band for members age 64+
- members' use of tobacco four or more times per week

### 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	Your Anthem Plan	Medicare is Primary
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	●	
	Upon completion of the 30-month Medicare entitlement period		●
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	●	
	If Medicare had been primary to the group plan before ESRD entitlement		●

### Recovery of overpayments

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

- any person to or for whom the overpayments were made;
- any health care company; 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.

### 1. Acts of War, Disasters, or Nuclear Accidents

In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

### 2. Administrative Charges

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

### 3. Alternative / Complementary Medicine

Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

- a) Acupuncture.
- b) Holistic medicine.
- c) Homeopathic medicine.
- d) Hypnosis.
- e) Aroma therapy.
- f) Massage and massage therapy.
- g) Reiki therapy.
- h) Herbal, vitamin or dietary products or therapies.
- i) Naturopathy.
- j) Thermography.
- k) Orthomolecular therapy.
- l) Contact reflex analysis.
- m) Bioenergetic synchronization technique (BEST).
- n) Iridology-study of the iris.
- o) Auditory integration therapy (AIT).
- p) Colonic irrigation.
- q) Magnetic innervation therapy.
- r) Electromagnetic therapy.
- s) Neurofeedback / Biofeedback.

### 4. Before Effective Date or After Termination Date

Charges for care you get before your Effective Date or after your coverage ends.

### 5. Charges Over the Maximum Allowed Amount

Charges over the Maximum Allowed Amount for Covered Services.

### 6. Charges Not Supported by Medical Records

Charges for services not described in your medical records.

**These services are not covered by your plan.**

## The ins and outs of coverage (continued)

### 7. Complications of Non-Covered Services

Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

### 8. Cosmetic Services

Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to:

- a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.
- b) Surgery or procedures to correct congenital abnormalities that cause functional impairment.
- c) Surgery or procedures on newborn children to correct congenital abnormalities. The Plan will not consider the patient's mental state in deciding if surgery is cosmetic.

### 9. Court Ordered Testing

Court ordered testing or care unless Medically Necessary.

### 10. Custodial Care

Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

### 11. Dental Exclusions

Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- a) Removing, restoring, or replacing teeth.
- b) Medical care or surgery for dental problems.
- c) Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded. This Exclusion does not apply to services that we must cover by law.

### 12. Educational Services

Services or supplies for teaching, vocational, or self-training purposes.

### Experimental ... or not?

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

- regulatory approval from the Food and Drug Administration;
- been put through extensive research study to find all the benefits and possible harms of the technology;
- benefits that are far better than any potential risks;
- at least the same or better effectiveness as any similar service or procedure already available; 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)

### 13. Experimental or Investigational Services

Services or supplies that we find are Experimental/Investigational. This also applies to services related to Experimental/Investigational services, whether you get them before, during, or after you get the Experimental/Investigational service or supply. The fact that a service or supply is the only available treatment will not make it a Covered Service if we conclude it is Experimental/Investigational.

### 14. Eyeglasses and Contact Lenses

Eyeglasses and contact lenses to correct your eyesight unless listed as covered. This Exclusion does not apply to lenses needed after a covered eye surgery.

### 15. Eye Exercises

Orthoptics and vision therapy.

### 16. Eye Surgery

Eye surgery to fix errors of refraction, such as nearsightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

### 17. Family Members

Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

### 18. Foot Care

Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

- a) Cleaning and soaking the feet.
- b) Applying skin creams to care for skin tone.
- c) Other services that are given when there is not an illness, injury or symptom involving the foot.

This exclusion does not apply to the treatment of corns, calluses, and care of toenails for members with diabetes or vascular disease.

### 19. Foot Orthotics

Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.

### 20. Foot Surgery

Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

### 21. Free Care

Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part.

This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

### 22. Hearing Aids

Hearing aids or exams to prescribe or fit hearing aids. This Exclusion does not apply to cochlear implants.

### 23. Health Club Memberships and Fitness Services

Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

**These services are not covered by your plan.**



## The ins and outs of coverage (continued)

### 24. Home Care

- a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
- b) Food, housing, homemaker services, and home delivered meals.

### 25. Infertility Treatment

Treatment related to infertility.

### 26. Maintenance Therapy

Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

### 27. Medical Equipment and Supplies

- a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- c) Non-Medically Necessary enhancements to standard equipment and devices.

### 28. Medicare

Services for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B and/or D, except as required by the federal law. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

### 29. Missed or Canceled Appointments

Charges for missed or canceled appointments.

### 30. Non-Medically Necessary Services

Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

### 31. Nutritional or Dietary Supplements

Nutritional and/or dietary supplements, except that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

### 32. Oral Surgery

Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth.

### 33. Personal Care and Convenience

- a) Items for personal comfort, convenience, protection or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
- b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
- c) Home workout or therapy equipment, including treadmills and home gyms.
- d) Pools, whirlpools, spas, or hydrotherapy equipment.
- e) Hypo-allergenic pillows, mattresses, or waterbeds,
- f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

**These services are not covered by your plan.**



## The ins and outs of coverage (continued)

### 34. Prescription Benefit Exclusions

Certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

- a) **Administration Charges**  
Charges for the administration of any Drug except for covered immunizations as approved by us or the (PBM).
- b) **Compound Drugs**  
Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.
- c) **Contrary to Approved Medical and Professional Standards**  
Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- d) **Delivery Charges**  
Charges for delivery of Prescription Drugs.
- e) **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
- f) **Drugs Not on the Anthem Prescription Drug List (a formulary)**  
You can get a copy of the list by calling us or visiting our website at [anthem.com](http://anthem.com).
- g) **Drugs That Do Not Need a Prescription**  
Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- h) **Drugs Over Quantity or Age Limits**  
Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
- i) **Drugs Over the Quantity Prescribed or Refills After One Year**  
Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
- j) **Fluoride Treatments**  
Topical and oral fluoride treatments.
- k) **Infertility Drugs**  
Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
- l) **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit.
- m) **Items Covered as Medical Supplies**  
Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.

**These services are not covered by your plan.**

## The ins and outs of coverage (continued)

- n) **Items Covered Under the “Allergy Services” Benefit**  
Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit.
  - o) **Lost or Stolen Drugs**  
Refills of lost or stolen Drugs.
  - p) **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider**  
Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
  - q) **Non-approved Drugs**  
Drugs not approved by the FDA.
  - r) **Off-label Use**  
Off-label use, unless we must cover the use by law or if we, or the PBM, approve it.
  - s) **Onychomycosis Drugs**  
Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno- compromised or diabetic.
  - t) **Over-the-Counter Items**  
Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products that we must cover under federal law with a Prescription.
  - u) **Sex Change Drugs**  
Drugs for sex change surgery.
  - v) **Sexual Dysfunction Drugs**  
Drugs to treat sexual or erectile problems.
  - w) **Syringes**  
Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
  - x) **Weight Loss Drugs**  
Any Drug mainly used for weight loss.
- 35. Private Duty Nursing**  
Private Duty Nursing Services. Your coverage does not include benefits for private duty nurses in the inpatient setting.
- 36. Prosthetics**  
Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.
- 37. Providers**  
Services you get from a non-covered Provider. Examples of non-covered Providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
- 38. Residential Treatment Centers**  
This exclusion does not apply when such setting qualifies as a substance use disorder treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care.
- 39. Sex Change**  
Services and supplies for a sex change and/or the reversal of a sex change.
- 40. Sexual Dysfunction**  
Services or supplies for male or female sexual problems.
- 41. Stand-By Charges**  
Stand-by charges of a Doctor or other Provider.

**These services are not covered by your plan.**

## The ins and outs of coverage (continued)

### 42. Reversal of Elective Sterilization

### 43. Surrogate Mother Services

Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

### 44. Telemedicine

Non-interactive telemedicine services, such as audio- only telephone conversations; electronic mail message or fax transmissions.

### 45. Temporomandibular Joint Treatment

Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

### 46. Travel Costs

Mileage, lodging, meals, and other Member-related travel costs.

### 47. Vein Treatment

Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

### 48. Vision Services

- a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.
- b) Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.
- c) Safety glasses and accompanying frames.
- d) For two pairs of glasses in lieu of bifocals.
- e) Plano lenses (lenses that have no refractive power)
- f) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
- g) Vision services not listed as covered in this Booklet.
- h) Cosmetic lenses or options.
- i) Blended lenses.
- j) Oversize lenses.
- k) Sunglasses and accompanying frames.
- l) For services or supplies combined with any other offer, coupon or in-store advertisement.
- m) For Members through age 18, no benefits are available for frames not on the Anthem formulary.
- n) Certain frames in which the manufacturer imposes a no discount policy

### 49. 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, etc.) and fasting programs.

### 50. Weight Loss Surgery Bariatric Surgery

This includes but is not limited to Roux-en-Y (RNY) Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries that lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty (surgeries that reduce stomach size) or gastric banding procedures.

**These services are not covered by your plan.**

# Information You Should Know

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

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

## Utilization management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, do medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

We can do medical reviews like this 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 you get medical care)

We may do a prospective review before a member goes to the hospital or has other types of service or treatment. Here are some types of medical needs that might call for a prospective review:

- A hospital visit
- An outpatient procedure
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans
- Certain types of outpatient therapy, like physical therapy or emotional health counseling
- "Durable medical equipment" (DME), like wheelchairs, walkers, crutches, hospital beds and more

### The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment, a stay in a nursing home, emotional health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

# Managing your care if you need to go to a hospital or get certain medical treatment (continued)

## The retrospective or post-service review (done after you get medical care)

We do a retrospective review when you have already had surgery or another type of medical care. When the UM review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can 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. They also help you better understand your health benefits.

## Preauthorization

Preauthorization is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are **based on standards of care in medical policies, clinical guidelines and the terms of your plan**. As these may change, **we review our preauthorization guidelines regularly**. Preauthorization is also called “precertification,” “prior authorization,” or “pre-approval.”

### Here’s how getting preauthorization can help you out:

**Saving time.** Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

**Saving money.** Paying only for medically necessary services helps everyone save. Choosing a doctor who’s in our network can help you get the most for your health care dollar.

**What can you do?** Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor’s office will ask for preauthorization for you. Plus, costs are usually lower with in-network doctors.

If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Non-network providers may not do that for you. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

There are times when we may need to do a benefit review for a health care service you plan to receive or have already received. We do this to find out what your plan will cover for that service. During the review, we take a look at the terms, benefits, limitations and exclusions of your particular plan. This means we may check to see if your plan covers the service, if you’ve already reached a benefit limit for the service, and if you can see a provider outside of the network. We may also review other aspects of your plan.

# Your rights and responsibilities as a member

As a 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.

## Your rights and responsibilities as a member (continued)

### 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.
- 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".



# 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 coinsurance.

## HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

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

### Your Protected Health Information

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

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

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

you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

**To Others:** In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

**As Allowed or Required by Law:** We may also share your PHI, 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. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

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

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

### 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.

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

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

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

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include 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.

# Important legal information you should take time to read

## 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.

## Effective Date of this Notice

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

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

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.

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

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 español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.



**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.**



**And Its Affiliate 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 for Anthem HealthKeepers plans. If you have questions, please contact your agent, Group Administrator, or member services: H-INTRO-HK (3/12), H-TOC (1/10), H-SB-POS (3/12), H-SB LUM (3/12), H-WORKS-HK (8/12), H-COVERED-HK (8/12), H-EXCL (3/12), H-CLAIMS-HK (1/12), H-COB (7/10), H-ENR (7/11), 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 (1/12), 490773 (1/12) This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031 Life and Disability products underwritten by Anthem Life Insurance. HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: PP-INTRO (3/12), P-TOC (07/10), P-SB6 (3/12), P-SB7 (3/12) P-COVERED (3/12), P-EXCL (3/12), P-CLAIMS (1/12), P-COB (07/10), P-ENR (10/10), P-ENDS (10/10), P-INFO-(1/12), P-RIGHTS (7/09), P-DEF (1/12), P-EXH-A (10/10), P-INDEX (07/10), P-ACC (07/10), GP-1 (7/02), GP-1-TOC, GP-1-ELIG (7/07), GP-1-GEN (1/12) Enrollment applications used for Anthem KeyCare or Lumenos: 490760 (1/12), 490773 (1/12) This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

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

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company. Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association.