



And Its Affiliate HealthKeepers, Inc.

Benefits You Can Count On

Newport News Public Schools

Anthem HealthKeepers HMO

KeyCare PPO

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





**Please share your
feedback with us
in this short survey.**

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
- 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).

Understanding your options for health care plans

We think it's important for you to have all the information you need before signing up for a health care plan. Take the time to think about your health care needs and learn how the plans work – so you can make the best decision for you and your family.

Ask these questions before signing up:

Does the plan:

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

Know the basics of how the plans work

- **Health Maintenance Organization (HMO):** An HMO gives you access to a wide range of services with low copays and low out-of-pocket costs. You get coverage for the doctors, hospitals and other health care providers that are in the plan's network. You have to choose a primary care physician (PCP) who directs your care and gives you referrals to see other doctors, if needed. To see how it works, visit anthem.com/HMObasics.
- **Preferred Provider Organization (PPO):** A PPO plan gives you coverage for doctors and hospitals that are in-network and out-of-network. But you save money by choosing in-network health care providers. To learn more, visit anthem.com/PPObasics.

Here are some definitions:

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

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

Copay: A fixed amount (for example, \$15) you pay for a covered health care service, usually when you received the service. The amount can vary by the type of covered health care service.

Know your costs

Health care plans differ in many ways. But with every plan, there's a basic premium, which is how much you and your employer each pay to buy the plan's coverage. The premium may only be a small part of your total cost. There are other payments you may make, which vary by plan. When choosing

Understanding your options for health care plans (continued)

a plan, try to figure out what the total cost is to you and your family, especially if someone in your family has a chronic or serious health condition.

Think about the following:

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

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

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Helpful links

anthem.com

While you're there check out the Health and Wellness tab

[Facebook.com/HealthJoinIn](https://www.facebook.com/HealthJoinIn)

While you're there check out the Health Personality Quiz

[Twitter.com/HealthJoinIn](https://twitter.com/HealthJoinIn)

[YouTube.com/HealthJoinIn](https://www.youtube.com/HealthJoinIn)

[Healthy Footprint](#)

[Glossary](#)

[Member Online Tools](#)



Your Health Benefits

Your Benefits

Anthem HealthKeepers 25 Newport News Public Schools

Covered Services	You Pay
Preventive Care Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.	*No Charge
Doctor Visits <ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ in-office surgery ○ voluntary family planning 	\$25 for each visit to your PCP \$50 for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests <ul style="list-style-type: none"> ○ diagnostic tests ○ diagnostic x-rays A copay does not apply when these services are provided by the same provider on the same day as the office visit. ○ lab work 	\$25 for each visit to your PCP \$50 for each visit to a specialist
<ul style="list-style-type: none"> ○ advanced diagnostic imaging services Your payment responsibility is waived if services are billed as a part of an emergency room visit. 	\$150 for each visit
Other Outpatient Services <ul style="list-style-type: none"> ○ hospice services ○ insulin pumps and oxygen ○ ambulance travel ○ partial day mental health and substance abuse services ○ durable medical equipment ○ home health care services ○ prosthetic devices ○ injectable medications* (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office) *You will also pay an additional \$25 or \$50 office visit copayment depending on the type of provider who treats you. 	No Charge \$100 per transport \$50 per calendar month 20% of the amount the health care professionals in our network have agreed to accept for their services
Therapy Services <ul style="list-style-type: none"> ○ occupational therapy ○ physical therapy ○ chemotherapy, radiation, cardiac and respiratory therapy ○ dialysis ○ spinal manipulation and manual medical therapy services 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. 	\$25 for each visit \$50 for each visit \$50 per calendar month \$25 for each visit
Outpatient Infusion Services <ul style="list-style-type: none"> ○ facility ○ ambulatory infusion centers ○ home services 	\$50 for each visit \$50 per calendar month for IV services \$50 per calendar month for IV services
Outpatient Surgery in a Hospital or Facility <ul style="list-style-type: none"> ○ surgery 	\$300 for each visit

For 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.

Covered Services	You Pay
Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> ○ skilled nursing facility (100 days for each admission) 	20% of the amount network health care professionals have agreed to accept for their services
<ul style="list-style-type: none"> ○ semi-private room ○ private room when approved when approved in advance ○ intensive or coronary care unit 	\$250 for per day (not to exceed \$1,500) for an admission
Maternity	
<ul style="list-style-type: none"> ○ all routine outpatient pre- and postnatal care (excluding inpatient stays) 	\$300 per pregnancy
<ul style="list-style-type: none"> ○ diagnostic testing (such as ultrasounds, non-stress tests and other fetal monitor procedures) 	\$50 for each visit
Outpatient Mental Health and Substance Abuse	
<ul style="list-style-type: none"> ○ medication management ○ individual therapy up to 30 minutes in length ○ group therapy 	\$20 for each visit
<ul style="list-style-type: none"> ○ other mental health and substance abuse visits 	\$30 for each visit
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <i>Plus valuable discounts on eyewear</i> 	\$15 for each visit
Emergency Care and Out of the Service Area Urgent Care	
<ul style="list-style-type: none"> ○ urgent care visits 	\$50 for each visit
<ul style="list-style-type: none"> ○ true emergency care visits in our out of the service area <i>*Waived if admitted directly to the hospital.</i> 	\$250 for each visit to an emergency room*

Out-of-Pocket Maximums
What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)
<p>If you are the only one covered by your plan, you will pay \$3,500 for covered services outlined in this insert. Once you have reached this amount, your payment for the covered services outlined in this insert is \$0, except for services listed below.</p> <ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay \$3,500 (\$7,000 total). ○ If three or more people are covered under your plan, together you will pay \$7,000. However, no family member will pay more than \$3,500 toward the limit. <p>The following do not count toward the calendar year out-of-pocket maximum. You will still need to pay:</p> <ul style="list-style-type: none"> ○ the costs associated with vision benefits ○ the cost of prescription drugs ○ the cost of dental benefits ○ the cost of care received when the benefit limits have been reached

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

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

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.

Anthem HealthKeepers 25/30/750 Newport News Public Schools

Your Anthem HealthKeepers Plan
Care rendered in a health care professional's office:
You will typically pay a set fee as noted below.
Inpatient facility and most outpatient facility services:
<ul style="list-style-type: none"> ○ You will pay all of the costs associated with your care until you have paid \$750 in one calendar year. ○ If two people are covered under your plan, each of you will pay the first \$750 of the cost of your care (\$1,500 total). ○ If three or more people are covered under your plan, together you will pay the first \$1,500 of your care. However, the most one family member will pay is \$750. <p>After you reach this amount, known as your deductible*, you will pay 30% of the amount that health care professionals in our network have agreed to accept for their services when services are received at a hospital or facility. This deductible does not apply to outpatient facility services related to preventive care.</p> <p>*The deductible is the amount you are required to pay in a calendar year (January 1 to December 31) toward the cost of your care before coverage for certain benefits begins.</p>

Covered Services	You Pay
Preventive Care	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.	
*During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.	*No Charge
Doctor Visits	
<ul style="list-style-type: none"> <li style="width: 50%;">○ office visits <li style="width: 50%;">○ in-office surgery <li style="width: 50%;">○ urgent care visits <li style="width: 50%;">○ voluntary family planning <li style="width: 50%;">○ home visits 	\$25 for each visit to your PCP* \$50 for each visit to a specialist
Labs, Diagnostic X-rays and Other Outpatient Diagnostic Tests	
<ul style="list-style-type: none"> <li style="width: 33%;">○ diagnostic x-rays <li style="width: 33%;">○ lab work <li style="width: 33%;">○ diagnostic tests <p>*This fee is not required when these services are provided by the same professional on the same day as the office visit.</p>	\$25 for each visit to your PCP \$50 for each visit to a specialist 30% for each visit to a hospital or facility (after meeting deductible, except for services related to preventive care)
<ul style="list-style-type: none"> ○ advanced diagnostic imaging services <p>Your payment responsibility is waived if services are billed as a part of an emergency room visit.</p>	\$150 for each visit 30% for each visit to a hospital or facility (after meeting deductible, except for services related to preventive care)
Other Outpatient Services	
<ul style="list-style-type: none"> <li style="width: 50%;">○ hospice services <li style="width: 50%;">○ durable medical equipment <li style="width: 50%;">○ insulin pumps and oxygen 	No Charge
○ ambulance travel	\$100 per transport
○ home health care services	\$50 per calendar month
○ dialysis	\$50 per calendar month

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. Covered services that are received during the last three months of the calendar year that are applied to your deductible may also be applied to the deductible required for the following year.

Covered Benefits	You Pay
Other Outpatient Services Continued	
<ul style="list-style-type: none"> ○ prosthetic devices 	30% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ injectable medications (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office) <i>You will also pay an additional \$25 or \$50 office visit copayment depending on the type of provider who treats you.</i> 	20% of the amount the health care professionals in our network have agreed to accept for their services
Therapy Service	
<ul style="list-style-type: none"> ○ occupational ○ physical ○ speech <i>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.</i> 	\$25 for each visit to a specialist's office 30% for each visit to a hospital or facility (after meeting deductible)
<ul style="list-style-type: none"> ○ chemotherapy ○ cardiac ○ radiation ○ respiratory 	\$50 for each visit to a specialist's office 30% for each visit to a hospital or facility (after meeting deductible)
<ul style="list-style-type: none"> ○ spinal manipulation and manual medical therapy services <i>Limited to 30 visits per calendar year.</i> 	\$25 for each visit
Outpatient Infusion Services	
<ul style="list-style-type: none"> ○ facility 	30% for each visit to a hospital or facility (after meeting deductible)
<ul style="list-style-type: none"> ○ ambulatory infusion centers 	\$50 per calendar month for IV services
<ul style="list-style-type: none"> ○ home services 	\$50 per calendar month for IV services
Outpatient Surgery	
<ul style="list-style-type: none"> ○ surgery 	30% for each visit to a hospital or facility (after meeting deductible, except for services related to preventive care)
Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room ○ private room when approved when approved in advance ○ skilled nursing facility ○ intensive or coronary care unit (100 days for each admission) 	30% for each stay at a hospital or facility (after meeting deductible)
Maternity	
<ul style="list-style-type: none"> ○ all routine outpatient pre- and postnatal care (excluding inpatient stays) 	\$300 per pregnancy
<ul style="list-style-type: none"> ○ diagnostic tests ○ non-stress tests and other fetal monitor procedures ○ ultrasounds 	\$50 for each visit to a specialist's office 30% for each visit to a hospital or facility (after meeting deductible)
Outpatient Mental Health and Substance Abuse Services	
<ul style="list-style-type: none"> ○ office visits 	\$25 for each visit
<ul style="list-style-type: none"> ○ outpatient facility (including partial day treatment and intensive outpatient programs) ○ outpatient facility professional provider services 	No charge
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <i>Plus valuable discounts on eyewear</i> 	\$15 for each visit
Emergency Care and Out of the Service Area Urgent Care	
<ul style="list-style-type: none"> ○ urgent care visits 	\$50 for each visit
<ul style="list-style-type: none"> ○ true emergency care visits in or out of the service area 	30% for each visit to an emergency room (after meeting 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 \$3,500 for covered services outlined in this insert. Once you have reached this amount, your payment for the covered services outlined in this insert is \$0, except for services listed below.

- If two people are covered under your plan, each of you will pay \$3,500 (\$7,000 total).
- If three or more people are covered under your plan, together you will pay \$7,000. However, no family member will pay more than \$3,500 toward the limit.

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

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

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

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See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.*

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Anthem KeyCare 500 Plan

In-Network Services	You Pay
Preventive Care Services Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which will result in a member cost share.	*No charge
Doctor Visits <ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ in-office surgery ○ pre and post natal care visits 	\$40 for each visit to PCP \$60 for each visit to Specialist
○ mental health and substance abuse visits	\$40 for each visit

All Other In-Network Services	You Pay
You will pay all the costs associated with your care until you have paid \$500 in one calendar year. This is known as your deductible. <ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay the first \$500 of the cost of your care (\$1,000 total). ○ If three or more people are covered under your plan, together you will pay the first \$1,000 of the cost of your care. However, the most one family member will pay is \$500. Once you reach your deductible you pay:	
Doctor Visits <ul style="list-style-type: none"> ○ physical and occupational therapy in an office setting (30 visit combined maximum) ○ speech therapy visits in an office setting (30 visit maximum) ○ spinal manipulations and other manual medical intervention visits (30 visit maximum) 	30% of the amount the health care professionals in our network have agreed to accept for their services
Labs, X-rays and Other Outpatient Services <ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays ○ dialysis ○ chemotherapy (not given orally) ○ radiation therapy ○ durable medical equipment ○ respiratory therapy ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ professional ground ambulance services 	30% of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Visits in a Hospital or Facility <ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 visit combined maximum) ○ speech therapy (30 visit maximum) ○ emergency room ○ surgery ○ physician services 	30% of the amount the health care professionals in our network have agreed to accept for their services

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

In-Network Services	You Pay
Care at Home <ul style="list-style-type: none"> ○ home health care visits by a nurse or aide ○ hospice care ○ private duty nursing (\$500 maximum) 	30% of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility <ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services ○ skilled nursing facility care (100 days for each admission) 	30% of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services

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

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$3,000 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first \$3,000 of the cost of your care (\$6,000 total).
- If three or more people are covered under your plan, together you will pay the first \$6,000 of the cost of your care. However, the most one family member will pay is \$3,000.

Once you have reached this amount, when you receive covered services we will pay 60% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$3,000 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

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

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

- If two people are covered under your plan, each of you will pay \$4,000 (\$8,000 total).
- If three or more people are covered under your plan, together you will pay \$8,000. However, no family member will pay more than \$4,000 toward the limit.

When not using network professionals
If you are the only one covered by your plan, you will pay \$6,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay \$6,000 (\$12,000 total).
- If three or more people are covered under your plan, together you will pay \$12,000. However, no family member will pay more than \$6,000 toward the limit.

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

- your share of the cost of prescription drugs
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 500 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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Your prescription drug plan

Your Prescription Drug 15-40-75 with \$150 Deductible Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	\$15	\$40	\$75
Up to a 90-day medication supply delivered to your home	\$30	\$80	\$150

This plan has a \$150 deductible per member per calendar year or \$300 per calendar year for the whole family toward second- and third- tier drugs only. Your deductible amount begins anew January 1 each year. Any amount you pay toward your deductible during the 4th quarter of each calendar year—October, November, December—will apply not only to your deductible for that year but will also apply to your deductible for the following year. After you meet your deductible on second-tier and third-tier drugs, simply pay the appropriate copayment shown in the chart above for each prescription.

Retail pharmacy network

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

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

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

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

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

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

Your prescription drug plan (continued)

- Safe, accurate prescriptions

Getting started with home delivery

Switching is simple. You can order by mail or fax. Your order should arrive within 14 days from the date your order is received.

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

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

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

By fax: Have your doctor fax your prescription and plan ID card 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
- Bleeding Disorders
- Cancer

Your prescription drug plan (continued)

- Cystic Fibrosis
- Crohn's Disease
- Growth Hormone
- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

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

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

Call 888-773-7376 to learn about how CareLogic can help you better manage your health condition.

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 9 p.m. and Saturday 9 a.m. to 1 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.
- Chose 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. Select your state, then click "Download Forms." You'll find the Drug List on this page.

Your prescription drug plan (continued)

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

If you're taking a brand name drug, you could save money by switching to an effective, lower cost generic drug. Your plan covers both brand and generic (or non-brand) drugs. When you choose a generic, you'll get the effectiveness of 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.

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.

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

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.

Take care of yourself

Remember to get preventive care

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

Our health plans cover 100% of the services listed in this preventive care flier.¹ When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care.

Here's a listing of the types of preventive services we cover. See your benefit plan to learn more.

Child preventive care (birth through 18 years)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests (depending on your age) may include

- Behavioral screening and counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Newborn screening
- Oral (dental health) assessment
- Screening and counseling for obesity
- Screening and counseling for sexually transmitted infections
- Type 2 diabetes screening
- Vision² screening

Take care of yourself (continued)

Immunizations

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

Adult preventive care (19 years and older)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests and services (depending on your age) may include

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- Breastfeeding support, supplies and counseling (female)^{3,4}
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Contraceptive (birth control) counseling and FDA-approved contraceptive medical services provided by a doctor, including sterilization (female)^{4,5}
- Depression screening
- Eye chart test for vision²
- Height, weight and BMI
- HIV screening and counseling
- HPV screening (female)⁴
- Intervention services (includes counseling and education):
 - Behavioral counseling to promote a healthy diet
 - Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin)
 - Counseling related to genetic testing for women with a family history of breast or ovarian cancer
 - Counseling related to chemoprevention for women with a high risk of breast cancer
 - Primary care intervention to promote breastfeeding

Take care of yourself (continued)

- Screening and behavioral counseling related to alcohol misuse
- Screening and behavioral counseling related to tobacco use
- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for obesity
- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, gestational diabetes⁴, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)
- Sexually transmitted infections
- Immunizations
- Type 2 diabetes screening

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A
- Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- MMR
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

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

- 1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost-share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your Ohio insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the customer care number on your ID card.
- 2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.
- 3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.
- 4 This benefit is covered under health care reform's women's preventive services. For group plan members, these services are covered with policy years beginning after August 1, 2012. For members with individual coverage, these benefits are effective for new members on or after August 1, 2012 and for current members on January 1, 2013. This benefit also applies to those younger than 19.
- 5 To get 100% coverage for a covered prescription for birth control, it must be a generic drug or a brand-name drug that doesn't have a generic equivalent. Also, you'll need to fill the prescription at an in-network pharmacy. A cost-share may apply for other prescription contraceptives, based on your drug benefits.



Ins and Outs of Coverage

The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

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

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

The ins and outs of coverage (continued)

Special enrollment periods

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

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 following services and supplies
will not be covered under your
Anthem HealthKeepers plan offered
by HealthKeepers, Inc.**

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 HealthKeepers, Inc.. Other dental services not covered by your plan include the following as noted below:

- shortening or lengthening of the mandible or maxillae for cosmetic purposes;
- surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services;
- dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia;
- medications to treat periodontal disease;
- reatment of natural teeth due to diseases;
- biting and chewing related injuries;
- restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth;
- extraction of either erupted or impacted wisdom teeth; and
- anesthesia and hospitalization for dental procedures and services except as specified within the Evidence of Coverage you will receive after enrollment.

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 HealthKeepers 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

The ins and outs of coverage (continued)

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

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

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

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

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

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

skilled nursing facility stays

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

smoking cessation programs not affiliated with us

spinal manipulation and manual medical therapy services (chiropractic care)

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

telemedicine

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

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

therapies

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

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


vision services

- vision services or supplies unless needed due to eye surgery and accidental injury routine vision care and materials
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- sunglasses or safety glasses and accompanying frames of any type
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames
- any blended lenses (no line), oversize lenses, progressive multifocallenses, photchromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- any other vision services not specifically listed as covered

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

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

These services are not covered by your Anthem HealthKeepers plan.



**The following services and supplies
will not be covered under the
KeyCare or Lumenos plan offered by
Anthem Blue Cross and Blue Shield.**

The ins and outs of coverage (continued)

What's not covered (exclusions)

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

acupuncture

biofeedback therapy

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

cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem. Other dental services that will not be covered by your plan include the following as noted below:

- treatment of natural teeth due to diseases;
- dental care, treatment, supplies, or dental x-rays;
- damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered;
- extraction of either erupted or impacted wisdom teeth;
- oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures;
- appliances for temporomandibular joint pain dysfunction; or
- periodontal care, prosthodontal care or orthodontic care.

The ins and outs of coverage (continued)

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

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

family planning

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

services for palliative or cosmetic **foot** care

- flat foot conditions
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- foot orthotics
- subluxations of the foot
- corns, calluses and care of toenails (except as 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

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

Experimental ... or not?

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

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

The ins and outs of coverage (continued)

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
- 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

The ins and outs of coverage (continued)

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

The following exceptions qualify for coverage.

For inpatients:

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

For outpatients:

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

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual deviation and dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
 - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the 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

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
- medications used to treat sexual dysfunction
- 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

These services are not covered under your KeyCare or Lumenos plan.

The ins and outs of coverage (continued)

- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies
- medicine furnished by any other drug or medical service

private duty nurses in the inpatient setting

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

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

services or supplies

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

services or supplies

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

These services are not covered under your KeyCare or Lumenos plan.

The ins and outs of coverage (continued)

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

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

services or benefits for:

- amounts above the allowable charge for a service
- self-administered services or self care
- self-help training
- biofeedback, neurofeedback, and related diagnostic tests

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

skilled nursing facility stays

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

smoking cessation programs not affiliated with us

spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions

telemedicine

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

therapies

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

These services are not covered under your KeyCare or Lumenos plan.

The ins and outs of coverage (continued)

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

vision services

- vision services or supplies unless needed due to eye surgery and accidental injury
- routine vision care and materials
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- sunglasses or safety glasses and accompanying frames of any type
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames
- any blended lenses (no line), oversize lenses, progressive multifocallenses, photchromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- any other vision services not specifically listed as covered

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

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

These services are not covered under your KeyCare or Lumenos plan.



Additional Benefits



WELCOME TO BLUE VIEW VISION!

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



**Blue View VisionSM
Exam Only A15 Plan**

Your Blue View Vision network

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

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES

- Routine eye exam** once every calendar year
- Retinal imaging** - at member’s option can be performed at time of eye exam

IN-NETWORK

- \$15 copay
- Discounted member cost not to exceed \$39

OUT-OF-NETWORK

- \$30 allowance
- 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

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

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

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

This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member’s policy, which shall control in the event of a conflict with this overview. Discounts referenced are not covered benefits under this vision plan and therefore are not included in the member’s policy. Frame discounts may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice. This benefit overview is only one piece of your entire enrollment package.



Health, Wellness & Anthem Advantages

Your Anthem plan has so much to offer, you won't want to miss a thing.

Register at anthem.com today!

Understanding your health plan just got a whole lot easier.

Your health; what's more important? So shouldn't understanding your health plan be just as important? We think so. So we made it easier, with anthem.com.

Once you register, you'll see how anthem.com makes complex information easy to understand and easy to use. You'll be able to know what's covered and what's not, what your costs will be for procedures, prescription drugs, doctor visits and so much more. Not only that, you can also save money and live better with our online tools that keep you informed, in control and at your healthy best. Take a look at all you can do:

Get an idea of what your costs will be before you go

Did you know that different hospitals and facilities charge different amounts for the same services? Now you can know your cost before you set foot in the hospital by going to anthem.com. By getting an estimate of your costs based on the benefits of your health plan, you can choose a facility that fits your budget.

To learn more visit anthem.com/costvideo.

Look up your claims

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 how much money you'll need to pay. You may also choose to get emails when claims have been processed, instead of getting notified by regular mail.

To learn how to get information about your claims, go to anthem.com/guidedtour/claim.

Find a Doctor (dentist, pharmacy or hospital)

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

To search our online Provider Finder:

- Log in at anthem.com
- Select "Find a Doctor" and follow the steps on the screen.

To learn about all the great tools on anthem.com go to anthem.com/guidedtour

Your Anthem plan has so much to offer, you won't want to miss a thing. (continued)

Get members' only discounts on health-related products and services through SpecialOffers

Enjoy discounts such as 20% savings on vitamins and supplements. Save \$20 with a minimum purchase of \$100, plus free shipping and free returns at 1-800 CONTACTS and Glasses.com. Get more from your membership by exploring over 50 discounts available to you.

To learn more about MyHealth Record go to anthem.com/guidedtour/record.

Isn't it time your life got a little easier. If you're not already registered at anthem.com, why not do it now? It's fast, secure and oh so easy!

360° Health® programs

Options. Extras. Support. Helping you improve your health and wellness.

Your health goals and needs are as unique as you are. What's right for one person is not always right for another. Maybe you're managing a health condition. Or maybe you want to stay healthy, eat better or get in shape. Whatever your needs, Anthem gives you a choice of programs to help you meet your personal goals in a way that fits you and helps you live your life to the fullest. From tips and tools to help you learn about preventive care to nurses who can answer your health questions anytime, 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.

To learn more about 360° Health, go to anthem.com. Look under Health and Wellness. Here are programs we offer:

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 registered nurses 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 go to the emergency room or urgent care for this? Where is the nearest one?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, it can help safeguard your health and the health of your family. To learn more visit anthem.com/nurseline_video.

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

If you are pregnant, we know your goal is to have a safe delivery and a healthy baby. Our Future Moms program helps you make healthy choices while you're pregnant and when you deliver your baby. 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. Our nurses will also call to see how you're doing.
- A helpful book: ***Your Pregnancy Week by Week*** and a maternity care diary.
- Tips and facts to help you handle any unexpected events.
- A questionnaire to see if you're at risk for preterm delivery.
- 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. To learn more visit anthem.com/futuremoms_video.

360° Health[®] programs (continued)

ConditionCare

If you or a covered family member 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 tools 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. To learn more visit anthem.com/conditioncare_video.

ConditionCare support programs

If you or a covered family member has certain types of cancer, vascular or musculoskeletal diseases, or low back pain, ConditionCare may be able to help. The program gives you toll-free, 24-hour access to Nurse Coaches. These coaches are registered nurses who can help you better control your condition and help you follow your doctor's care plan. A team of pharmacists, dietitians and health educators work together to help you. ConditionCare also gives you the information and tools that can help you avoid unnecessary visits to the doctor, hospital stays and time away from work.

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.

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.

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 all talk 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.



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.
- Prosthesis 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

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

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 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.

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.



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.



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.