Evidence of Coverage

University of Richmond

Lumenos Health Savings Account ($2600/100%)

Take Control of Your Health

Offered by Healthkeepers, Inc.
Anthem Healthkeepers
HealthKeepers, Inc.
Anthem HealthKeepers Lumenos Health Savings Account
Plan – Evidence of Coverage

This Evidence of Coverage (“EOC”) fully explains your health care benefits. Treat it as you treat the owner’s manual for your car - store it in a convenient place and refer to it whenever you have questions about your health care coverage.

Important: This is not an insured benefit plan. The benefits described in this evidence of coverage or any amendments hereto are funded by the employer who is responsible for their payment. HealthKeepers, Inc. provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This health plan is intended to be federally tax qualified and compatible with a qualified health savings account. Approval by the Bureau of Insurance does not guarantee tax qualification and this health plan has not been submitted for approval by the IRS. Please seek the counsel of a tax advisor.

Important phone numbers
Member Services
800-582-6941

How to obtain language assistance
HealthKeepers is committed to communicating with our members about their health plan, regardless of their language. HealthKeepers employs a Language Line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services. In the event of a dispute, the provisions of the English version will control.

| Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente. |
| (If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number.) |

Hours of operation:
Monday-Friday
8:00 a.m to 6:00 p.m.
Saturday
9:00 a.m. to 1:00 p.m.

24-hour Nurse Advisor Line (Medical Questions and Future Moms)
866-800-8780
Keywords
There are a few key words you will see repeated throughout this EOC. We've highlighted them here to eliminate confusion and to make the EOC easier to understand. In addition, we have included a Definitions section on page 72 that lists various words referenced. A defined word will be italicized each time it is used.

Helpful tip: Look for these icons to identify which services are considered inpatient and which are outpatient.

HealthKeepers, we, us, our
Refers to HealthKeepers, Inc.

Subscriber
The eligible employee as defined in the agreement who has elected coverage for himself/herself and his/her dependents (if any) who meet the eligibility requirements of this EOC and enrolls in HealthKeepers, and for whom the premium required by the agreement has been paid to HealthKeepers.

Member
Any subscriber or enrolled dependent.

You, your
Any member.

Outpatient
Care received in a hospital outpatient department, emergency room, professional provider's office, or your home.

Inpatient
Care received while you are a bed patient in the hospital.
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Summary of benefits

This chart is an overview of your benefits for covered services. They are listed in detail beginning on page 17. A list of services that are not covered begins on page 36.

What will I pay?

This chart shows the most you pay for calendar year deductibles and annual copayment and coinsurance (if any) limits for covered services in one year of coverage. All covered benefits are subject to the deductible except for in-plan wellness services and routine eye exams.

The out-of-pocket limit generally includes all deductibles, copayments (if any) and coinsurance you pay during a calendar year. It does not include charges over the maximum allowed amount or amounts you pay for non-covered services. Please see the Claims and payments section for additional details.

Both in-plan and out-of-plan services accumulate toward the calendar year deductible. Amounts applied toward the calendar year deductible will also apply to both the in-plan and out-of-plan out-of-pocket expense limits. However, the out-of-pocket expense limits for in-plan and out-of-plan services are separate, and amounts applied to one limit do not apply to the other. Coinsurance amounts for in-plan services apply only to the in-plan limit, and coinsurance amounts for out-of-plan services apply only to the out-of-plan limit.

<table>
<thead>
<tr>
<th></th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar year deductible</td>
<td>$2600</td>
<td>$5200</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>The most you will pay per calendar year for in-plan services</td>
<td>$3500</td>
<td>$7000</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>The most you will pay per calendar year for out-of-plan services</td>
<td>$5000</td>
<td>$10000</td>
<td></td>
<td>46</td>
</tr>
</tbody>
</table>

If you cover only yourself, then you must satisfy the per member deductible before any covered services are paid by the health plan. Once the per member out-of-pocket expense limit has been reached, no additional coinsurance will be required of you for the remainder of the calendar year.

If you cover yourself and one other dependent, then each of you must satisfy the per member deductible before any covered services are paid by the health plan. When the per member out-of-pocket expense limit is reached by each person, then no additional coinsurance will be required for that person for the remainder of the calendar year.

In the event that you cover three or more people, then the family deductible may be satisfied and the family out-of-pocket expense limit may be reached by a combination of any family member’s expenses. The per member deductible amount is the most that must be satisfied by any one covered person before covered services are paid by the health plan. The per member out-of-pocket expense is the most that any one covered person will pay per calendar year. Once the family out-of-pocket expense limit has been satisfied, no additional coinsurance will be required of the family for the remainder of the calendar year.

<table>
<thead>
<tr>
<th></th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance travel (Air and Water)</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td>17</td>
</tr>
<tr>
<td>Ambulance travel (Ground)</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td>17</td>
</tr>
</tbody>
</table>
## 2- Summary of benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Copayment</td>
<td>Coinsurance</td>
<td>Copayment/coinsurance determined by service rendered</td>
</tr>
<tr>
<td></td>
<td>(after calendar year deductible)</td>
<td>(after calendar year deductible)</td>
<td></td>
</tr>
<tr>
<td>Autism services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applied behavior analysis</td>
<td>$0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>All other services for autism</td>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical trials</td>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic supplies, equipment, and education</td>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic tests and services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>For specific conditions or diseases at an emergency room or outpatient facility department.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis treatments</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Doctor visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On an outpatient basis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Specialty Care Providers</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Early intervention services*</td>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered up to age 3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency room visits</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Covered only for true emergency services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>100-visit calendar year limit per member.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice care services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per stay</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Outpatient treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Infusion services-outpatient services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Ambulatory infusion centers</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Home services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Lymphedema</td>
<td>Copayment/coinsurance determined by service rendered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per stay</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Prenatal, postnatal and delivery</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity related, such as ultrasounds and fetal monitor procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Summary of benefits continued
### Summary of benefits - 3

<table>
<thead>
<tr>
<th>Medical equipment (durable), devices, appliances, formulas, supplies and medications</th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment</td>
<td>Coinsurance (after calendar year deductible)</td>
<td>Coinsurance (after calendar year deductible)</td>
<td></td>
</tr>
<tr>
<td>Medical equipment (durable), devices and appliances</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Medical formulas, supplies and medications</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Injectable medications</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Excludes allergy injections/serum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetics</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Mental health and substance use disorder

**Inpatient admission**
(includes residential treatment centers)

<table>
<thead>
<tr>
<th>Facility services</th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per stay</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Partial day program**

| $0 | 0% | 30% | |

**Outpatient treatment**

| Medication management, individual therapy sessions up to 30 minutes in duration, and group therapy sessions | $0 | 0% | 30% | |
| All other outpatient mental health and substance use disorder visits | $0 | 0% | 30% | |

### Nutritional counseling

**For eating disorders**

| Copayment/coinsurance determined by service rendered | |
| Skilled nursing facility stays* | $0 | 0% | 30% | 25 |

**100-day per stay limit**

| Spinal manipulation and manual medical therapy services * | $0 | 0% | 30% | 25 |

30-visits calendar year limit per member. To receive the highest level of benefits, services must be received by a provider that participates in the American Specialty Health Group (ASHG).

### Surgery

**Inpatient admission**

<table>
<thead>
<tr>
<th>Facility services</th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per stay</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Outpatient treatment**

<table>
<thead>
<tr>
<th>Facility services</th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Therapy – outpatient services

**Chemotherapy, radiation, cardiac rehabilitation and respiratory**

<table>
<thead>
<tr>
<th>Facility services</th>
<th>In-plan</th>
<th>Out-of-plan</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Summary of benefits continued**
<table>
<thead>
<tr>
<th>Service</th>
<th>In-plan Copayment</th>
<th>In-plan Coinsurance (after calendar year deductible)</th>
<th>Out-of-plan Coinsurance (after calendar year deductible)</th>
<th>Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, speech, and occupational *</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td>27</td>
</tr>
<tr>
<td>30 combined visits per member per calendar year for physical and occupational therapy; 30 visits per member per calendar year for speech therapy. Limit does not apply to autism services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Professional provider services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Wellness services</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td>28</td>
</tr>
<tr>
<td>for children and adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The calendar year deductible does not apply to wellness services received in plan; however, if wellness services are received from out-of-plan providers, the services will be subject to the calendar year deductible. Screenings received for diagnostic purposes (as billed by the in or out-of-plan provider or facility) are not considered to be wellness services, and therefore will also be subject to the calendar year deductible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wigs</td>
<td>$0</td>
<td>0%</td>
<td>30%</td>
<td>30</td>
</tr>
<tr>
<td>Limited to one wig per member per year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Services received in-plan and out-of-plan accumulate toward this maximum/limit.
Prescription drug retail pharmacy and home delivery (mail order) benefits

Each prescription drug will be subject to a cost share (e.g., copayment / coinsurance) as described below. If your prescription order includes more than one prescription drug, a separate cost share will apply to each covered drug.

Day/supply limitations
Prescription drugs will be subject to various day supply and quantity limits. Certain prescription drugs may have a lower day-supply limit than the amount shown below due to other plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

<table>
<thead>
<tr>
<th>Location</th>
<th>Days of Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail pharmacy (in-network and out of network)</td>
<td>30 days</td>
</tr>
<tr>
<td>Home delivery (mail order)</td>
<td>90 days</td>
</tr>
<tr>
<td>Specialty pharmacy (in-network and out-of-network)</td>
<td>30 days*</td>
</tr>
</tbody>
</table>

*See additional information in the “Specialty drug copayments /coinsurance” later in this section.

Retail pharmacy copayments / coinsurance

<table>
<thead>
<tr>
<th>Tier</th>
<th>Copayment</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>$30</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>$50</td>
<td>0%</td>
</tr>
</tbody>
</table>

Home delivery pharmacy copayments / coinsurance

<table>
<thead>
<tr>
<th>Tier</th>
<th>Copayment</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$25</td>
<td>0%</td>
</tr>
<tr>
<td>2</td>
<td>$75</td>
<td>0%</td>
</tr>
<tr>
<td>3</td>
<td>$125</td>
<td>0%</td>
</tr>
</tbody>
</table>

Specialty drug copayments / coinsurance

Please note that certain specialty drugs are only available from a specialty pharmacy and you will not be able to get them at a retail pharmacy or through the home delivery (mail order) pharmacy. Please see “Specialty pharmacy” in the section “Prescription drug benefit at a retail or home delivery (mail order) pharmacy” for further details. When you get specialty drugs from a specialty pharmacy, you will have to pay the same copayments / coinsurance you pay for a 30-day supply at a retail pharmacy.

Note: Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments when you get them from an in-network pharmacy. These supplies are covered as medical supplies and durable medical equipment if you get them from an out-of-network pharmacy. Diabetic test strips are covered subject to applicable prescription drug copayment / coinsurance.
How your coverage works

Your coverage provides a wide range of health care services. The information contained in this section is designed to help you understand how you can access your benefits. For more specific information on copayments and benefit limits, please refer to your Summary of benefits.

Your coverage is a self-funded employee welfare benefit plan sponsored by your employer. The cost of your coverage, which includes the plan benefits and administrative expenses, is borne by your employer. Employees may contribute to the cost through payroll deduction. Your employer has entered into an administrative services contract with HealthKeepers, Inc. to carry out certain functions with respect to claims operation.

Carry your identification (“ID”) card
Your coverage ID card identifies you as a member and contains important health care coverage information. Carrying your card at all times will ensure you always have access to this coverage information with you when you need it. Make sure you show your ID card to your doctor, hospital, pharmacist, or other health care provider so they know you’re a HealthKeepers member. HealthKeepers providers have agreed to submit claims to us on your behalf.

Primary Care Physicians (“PCP”)
Your PCP will provide your primary health care services such as annual physicals and medical tests, oversee care when you are ill or injured, and treat any chronic health problems or diseases. You should establish a personal and continuous relationship with your PCP. Building and maintaining this ongoing relationship is an important part of health care.

Your coverage does not require that you obtain a referral from your PCP to receive care from other HealthKeepers providers. However, you may want to let your PCP know about other HealthKeepers providers that are treating you so that your PCP can better oversee your health care.

Selecting or changing your Primary Care Physician
You will need to select a PCP from a directory of participating providers in order to receive benefits. Each covered family member may select a different PCP. If you do not select a PCP upon enrollment or if the PCP you previously selected is no longer with the HealthKeepers network, then we may select a PCP for you. Your ID card will list your PCP’s name or your PCP’s group name. If you are not satisfied with your PCP, then you may request another participating PCP. If your PCP leaves the HealthKeepers network, you will receive a letter notifying you of the change in the network. We cannot guarantee the continued availability of a particular HealthKeepers provider.

You may change your PCP for a number of reasons; for example, if you or your PCP moves or if your work hours or your PCP’s hours change. You may change your PCP by calling Member Services and placing your request by telephone. You may also change your PCP by completing and submitting a change form. The change will be effective the first of the month following your telephone call or receipt of your change form.
As long as your new PCP is accepting patients, your change request should go through. If the PCP you selected is not accepting new patients, you may have to select another PCP. Requesting a change in PCP is limited to once a month.

**Note:** You may call Member Services for information regarding the qualifications of providers in; HealthKeepers network. Qualifications include: medical school attended, residency completed and board certification.

**Note:** If you change PCPs, make sure you notify us before seeing the new PCP. A request for a PCP change after you’ve seen the new PCP will not be accepted.

**The advance approval process**

HealthKeepers providers are required to obtain prior authorization in order for you to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. HealthKeepers may determine that a service that was initially prescribed or requested is not medically necessary if you have not previously tried alternative treatments which are more cost effective.

HealthKeepers will make coverage decisions on services requiring advance approval within 15 days from the receipt of the request. HealthKeepers may extend this period for another 15 days if HealthKeepers determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, HealthKeepers will make its decision within 2 working days of its receipt of all necessary clinical information needed to process the advance approval request.

For urgent care claims, coverage decisions will be completed and we will respond to you and your provider as soon as possible taking into account your medical condition, but not later than 72 hours from receipt of the request. If insufficient information is submitted in order to review the claim, we will ask you or your provider for the information needed within 24 hours of the receipt of your request, and make our decision within 48 hours of receiving the information. If the requested information is not received within 48 hours of our request, we will make our decision within 96 hours from the date of our request.

Once HealthKeepers has made a coverage decision on services requiring advance approval, you will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of HealthKeeper’s appeal procedures and applicable time limits;
- in the case of an urgent care claim, a description of the expedited appeal and expedited review process applicable to such claims; and
the availability of, and contact information for, the U.S. Department of Labor’s Employee Benefits Security Administration that may assist you with the internal or external appeals process.

If all or part of a pre-service or urgent care claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that HealthKeepers relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive, upon request and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to the patient’s medical condition.

HealthKeepers may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in HealthKeeper’s discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, we may select certain qualifying providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because HealthKeepers exempts a process, provider or claim from the standards which otherwise would apply, it does not mean that HealthKeepers will do so in the future, or will do so in the future for any other provider, claim or member. HealthKeepers may stop or modify any such exemption with or without advance notice.

You may determine whether a provider is participating in certain programs by checking the provider directory or contacting the Member Services number on the back of your ID card.

We also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this plan’s members.

Approvals of care involving an ongoing course of treatment
HealthKeepers providers must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If you are receiving care from a non-HealthKeepers provider and need to receive an extension of a previously approved course of treatment, you will be required to ask for the extension. You should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. We will notify you of our coverage decision within 24 hours of your request.

If we make a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an adverse benefit determination. If the reduction or termination was not a result of a health plan amendment or health plan termination, we will notify you in advance of the reduction or termination in sufficient time for you to file an internal appeal prior to the reduction or termination.
**Non-HealthKeepers providers**

In the event that you receive covered services from a non-HealthKeepers provider, then we reserve the right to make payment of such covered services directly to you, the non-HealthKeepers provider, or any other person responsible for paying the non-HealthKeepers provider’s charge. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-HealthKeepers provider. If you receive services from a non-HealthKeepers provider without the proper authorization, you will receive out-of-plan benefits. In addition, you may be responsible for any charges over our maximum allowed amount and this amount will not apply toward your annual copayment limit.

Services for spinal manipulation and manual medical intervention are typically performed by a provider within the American Specialty Health Group (ASHG). To receive care for these services from a non-ASHG provider, contact ASHG directly for authorization. If authorization is not received, you will be responsible for all costs related to these services.

**Terminated providers**

The HealthKeepers network is subject to change as health care providers are added to the network, move, retire, or change their status. When providers decide to leave the network, they become non-participating providers, and services, unless properly authorized, will not be covered.

There are three instances when members may continue seeing providers who have left the network:

1. A member in the second or third trimester of pregnancy may continue seeing her obstetrician-gynecologist through postpartum care for that delivery.
2. Members with life expectancy of six months or less may continue seeing their treating physician.
3. You have chosen to receive services on an out-of-plan basis.

**Guest Memberships**

When you or any of your dependents will be staying temporarily outside of the service area for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated health maintenance organization in that area. An example of when this service may be utilized is when a dependent student attends a school outside of the service area. Call a Member Services representative at 866-823-5391 to make sure that the area in which you or your dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated health maintenance organization plans. If the area is within the network, you will need to complete a guest membership application and you will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield health maintenance organization affiliate where you or your covered dependents will be staying. Member Services will explain any limitations or restrictions to this benefit. If you are staying in an area that is not within the Guest Membership Network, this service will not be available.

**The difference between emergency care and urgent care**
An emergency is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual’s body functions;
- serious dysfunction of any of the individual’s bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of urgent care situations include high fever, vomiting, sprains or minor cuts.

Note: If you cannot contact your PCP or are unsure if your condition requires emergency or urgent care, the 24/7 NurseLine is available to assist you 7 days a week.

When you need to access health care (within the service area)

- Medical care is available through your PCP 7 days a week, 24 hours a day. If you need care after regular office hours you may contact the on-call PCP or the 24/7 NurseLine. For instructions on how to receive care, call your PCP or the 24/7 NurseLine at 866-800-8780.
- If your condition is an emergency, you should be taken to the nearest appropriate medical facility.
- Your coverage includes benefits for services rendered by providers other than HealthKeepers providers when the condition treated is an emergency as defined in this EOC.

When you are away from home (outside the service area) and need to access care

HealthKeepers does business only within a certain geographic area in the Commonwealth of Virginia. See The BlueCard Program below for covered services received outside of Virginia. Services outside the service area are provided to help you if you are injured or become ill while temporarily away from the service area. In order to receive in-plan benefits for these services, you must satisfy any authorization requirements outlined in this EOC and obtain care from a health care provider that has a contractual arrangement with the local Blue Cross and/or Blue Shield licensee in the area where you are being treated. The BlueCard Program section provides additional details and you may locate a contracting provider by visiting www.anthem.com or calling Member Services.

If you need to access care when you are temporarily outside the service area:

- you should obtain care at the nearest medical facility if you have an emergency or urgent care situation;
- you will be responsible for payment of charges at the time of your visit; and
- you should obtain a copy of the complete itemized bill for filing a claim with HealthKeepers. For more information on filing claims see When you must file a claim on page 49.
Out-of-Area Services

*HealthKeepers* has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside *HealthKeepers’s* service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between *HealthKeepers* and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside *HealthKeepers’s* service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare Providers. *HealthKeepers’s* payment practices in both instances are described below.

The BlueCard® Program

Under the BlueCard® Program, when you obtain Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, *HealthKeepers* will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Health Care Services, as defined above, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the copayment amount, as stated in your Evidence of Coverage.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the *HealthKeepers* service area, go to the nearest Emergency or Urgent Care facility.

Whenever you access covered health care services outside the *HealthKeepers* service area and the claim is processed through the BlueCard Program, the amount you pay for covered health care services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to *HealthKeepers*.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price *HealthKeepers* uses for your claim because they will not be applied retroactively to claims already paid.
Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered health care services according to applicable law.

Please refer to the Claims and payments section of this EOC for information on Non-Participating providers and facilities.

You can also access doctors and hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide
Before you travel outside the United States, check with your group or call customer service at the number on your identification card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the customer service number on your identification card for coverage details.
- Always carry your up to date HealthKeepers identification card.
- In an emergency, go straight to the nearest hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a doctor visit or hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a doctor or hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a doctor visit or hospital stay, if needed.
- You need inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your identification card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- Participating BlueCard Worldwide Hospitals. In most cases, when you make arrangements for a hospital stay through BlueCard Worldwide, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-covered services, deductible, copayments and coinsurance) you normally pay. The hospital should send in your claim for you.
- Doctors and/or non-participating hospitals. You will need to pay upfront for outpatient services, care received from a doctor, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The hospital will file your claim if the BlueCard Worldwide Service Center arranged your hospital stay. You will need to pay the hospital for the out-of-pocket costs you normally pay.
• You must file the claim for outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the provider and subsequently send an International claim form with the original bills to us.

Claim Forms
You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at http://www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Note: In the event that you travel outside of Virginia and receive covered services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider's service(s) will be considered out-of-network care, and you may be billed the difference between the charge and the allowable charge. You may call Member Services or go to www.anthem.com for information regarding such arrangements.

Notification
HealthKeepers will participate in coordinating your care if you are hospitalized as a result of receiving emergency services. You or a representative on your behalf should notify HealthKeepers within 48 hours after you begin receiving care. This applies to services received within or outside the service area.

Hospital admissions
All non-emergency hospital admissions must be arranged by the member's admitting HealthKeepers physician and approved in advance by HealthKeepers, except for maternity admissions as specified in the maternity section of this EOC. We also reserve the right to determine whether the continuation of any hospital admission is medically necessary. For emergency admissions, refer to the preceding paragraph Notification.

HealthKeepers will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. HealthKeepers may extend this period for another 15 days if HealthKeepers determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 15-day period.

In cases where the hospital admission is an urgent care claim, a coverage decision will be completed within 24 hours. Your physician will be notified verbally of the coverage decision within this timeframe.

Once a coverage decision has been made regarding your hospital admission, you will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:
• information sufficient to identify the claim involved;
• the specific reason(s) and the plan provision(s) on which the determination is based;
• a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
• a description of HealthKeeper's appeal procedures and applicable time limits;
• in the case of an urgent care claim, a description of the expedited review process applicable to such claims; and
• the availability of, and contact information for, the U.S. Department of Labor’s Employee Benefits Security Administration that may assist you with the internal or external appeals process.

If all or part of a hospital admission was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that HealthKeepers relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive upon request, and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to your medical condition.

Hospital admissions for covered radical or modified radical mastectomy shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of stay for maternity admissions is determined according to the Newborn’s and Mother’s Health Protection Act. This federal law allows for 48 hours for vaginal delivery or 96 hours for caesarian section. Admissions for maternity care do not, initially, require Hospital Admission Review. However, if complications develop and additional days are necessary, Hospital Admission Review is required. We request that your doctor contact HealthKeepers to establish eligibility and waiting periods.

Out-of-plan
You must initiate pre-admission authorization from HealthKeepers if you choose to receive out-of-plan care. This is necessary for all out-of-plan non-emergency inpatient admissions including admissions for mental health and substance abuse conditions. If authorization is not received from HealthKeepers, you will be responsible for all costs (physician, non-physician, and facility) related to the hospital stay.

Health plan individual case management
Our health plan case management programs (Case Management) help coordinate services for members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any covered services you are receiving.
If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating doctor(s), and other providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a covered service through our Case Management program. We may also extend covered services beyond the benefit maximums of this plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the member and HealthKeepers. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

Also, from time to time HealthKeepers may offer a member and/or their HealthKeepers provider information and resources related to disease management and wellness initiatives. These services may be in conjunction with the member’s medical condition or with therapies that the member receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

In addition to the covered services listed in this EOC, we may provide certain benefits to help covered persons manage their chronic health conditions. If you have a chronic condition such as diabetes or hypertension, you can find out more about these benefits by calling the Member Services number on your I.D. card.

**Voluntary clinical quality programs**

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests within a specific timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from covered services under your plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program’s timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

**Voluntary wellness incentive programs**
We may offer health or fitness related program options for purchase by your group to help you achieve your best health. These programs are not covered services under your plan, but are separate components, which are not guaranteed under this plan and could be discontinued at any time. If your group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the customer service number on your ID card and we will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

**If you changed coverage within the year**
Your health plan may include calendar year limitations on deductibles, out-of-pocket expenses, or benefits. These limitations may be affected by a change of health plan coverage during the calendar year.

- If you change from one employer's health plan to another employer's health plan during the calendar year, new benefit limitations and out-of-pocket amounts will apply as of your effective date of coverage under the new employer's health plan. Amounts that may have accumulated toward specific benefits or out-of-pocket amounts under your former employer's health plan will not count under your new employer's health plan.

- If you do not change employers, but move from coverage other than HealthKeepers coverage (issued by any Anthem-affiliated health maintenance organization) to HealthKeepers coverage during the calendar year, new benefit limitations and out-of-pocket amounts will apply as of the effective date of your HealthKeepers coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket amounts under the other coverage will not count under the HealthKeepers coverage.

- If you do not change employers, but move from one HealthKeepers benefit plan or option to another HealthKeepers benefit plan or option during the calendar year, any amounts that had accumulated toward the calendar year benefit limitations and out-of-pocket amounts before the change will count under the new HealthKeepers benefit plan or option for the remainder of the calendar year.
What is covered

All benefits are subject to the terms, conditions, definitions, limitations, and exclusions described in this EOC. Only medically necessary covered services will be provided by HealthKeepers. If a service is not considered medically necessary, you will be responsible for the charges. Additionally, we will only pay the charges incurred by you when you are actually eligible for the covered services received (for example, the premium has been paid by you or on your behalf).

The following pages describe the benefits available to you under this EOC.

Ambulance service

Medically necessary ambulance services are a covered service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical emergency to a hospital;
  - Between hospitals, including when we require you to move from an out-of-network hospital to an in-network hospital
  - Between a hospital and a skilled nursing facility or other approved facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical emergency to a hospital;
  - Between hospitals, including when we require you to move from an out-of-network hospital to an in-network hospital
  - Between a hospital and an approved facility.

Ambulance services are subject to medical necessity reviews by us. When using an air ambulance for non-emergency transport, we reserve the right to select the air ambulance provider. If you do not use the air ambulance provider we select, the out-of-network provider may bill you for any charges that exceed the plan’s maximum allowed amount.

You must be taken to the nearest facility that can give care for your condition. In certain cases, we may approve benefits for transportation to a facility that is not the nearest facility.

Benefits also include medically necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a facility.
**Important Notes on Air Ambulance Benefits**

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a facility than the ground ambulance can provide, the plan will cover the air ambulance.

Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach. Air ambulance will not be covered if you are taken to a hospital that is not an acute care hospital (such as a skilled nursing facility), or if you are taken to a physician's office or your home.

**Hospital to Hospital Transport**

If you are moving from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain hospitals. To be covered, you must be taken to the closest hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your provider prefers a specific hospital or physician.

**Autism services**

*Your* coverage includes certain treatments associated with autism spectrum disorder (ASD) for dependents from age two through age six. Coverage for ASD includes but is not limited to the following:

- diagnosis of autism spectrum disorder;
- treatment of autism spectrum disorder;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

Treatment for ASD includes *applied behavior analysis* when provided or supervised by a board certified behavior analyst, licensed by the Board of Medicine, and billed by such behavior analyst, and the prescribing practitioner is independent of the provider of the *applied behavior analysis*.

**Clinical trial cost**

*Your* coverage includes benefits for clinical trial costs. Clinical trial costs means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer. The criteria for these costs is found in Exhibit A.

**Dental Services (All Members/All Ages)**

**Preparing the Mouth for Medical Treatments**

*Your* plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. *Covered services* include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia
Treatment of Accidental Injury
Benefits are also available for dental work needed to treat injuries to the jaw, teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an accidental injury under this plan, unless the chewing or biting results from a medical or mental condition. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.

Hospitalization for Anesthesia and Dental Procedures
Your plan includes coverage of general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.

Note: HealthKeepers provides coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by HealthKeepers, are not covered service.

Diabetic supplies, equipment, and education
Your coverage provides for medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:
- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes and hypodermic needles and syringes when received from a HealthKeepers pharmacy; and
- outpatient self-management training and education performed in-person, including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.
Screenings for gestational diabetes are covered under Wellness services.

Diagnostic tests
Your benefits include coverage for the following procedures when performed by the designated HealthKeepers providers to diagnose a definite condition or disease because of specific signs and/or symptoms:
- radiology (including mammograms), ultrasound or nuclear medicine
- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs; and
- advanced diagnostic imaging services (includes magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), magnetic resonance spectroscopy (MRS), positron emission tomography (PET) scan, computed tomography (CT) scan, and computed tomographic angiography (CTA).

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital stay is covered under your benefits only when:
- your medical condition requires that medical skills be constantly available;
- your medical condition requires that medical supervision by your doctor is constantly available; or
- diagnostic services and equipment are available only as an inpatient.
Note: Medical supplies and other services that may be required and provided in conjunction with a diagnostic test are not considered part of the diagnostic test. Therefore, if a facility or provider bills a separate charge for such services or supplies, benefits for such services or supplies will be provided as described in the Summary of Benefits for such services and supplies and not as part of the diagnostic test.

Dialysis

Your coverage provides for dialysis treatment, including hemodialysis and peritoneal dialysis. These are treatments of severe kidney failure or chronic poor functioning of the kidneys.

Doctor visits and services

Call your PCP when you are in need of health care services. Your coverage provides for:

- visits to a doctor's office or your doctor's visits to your home;
- visits to an urgent care center;
- visits to an ambulatory surgery center;
- doctor visits in a hospital outpatient department or emergency room;
- visits for shots needed for treatment (for example, allergy shots); and
- interactive telemedicine services.

Early intervention services

Your coverage includes benefits for early intervention services for covered dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (“the Department”) as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be medically necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not medically necessary.

Emergency room care

Your benefits include coverage for emergency room visits, services, and supplies necessary for the treatment of an emergency as defined in the Definitions section at the back of this EOC.

Home care services
When authorized by HealthKeepers, we cover treatment provided in your home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat your condition. To ensure benefits, your doctor must provide a description of the treatment you will receive at home. Your coverage includes the following home health services:

- visits by a licensed health care professional, including a nurse, therapist, or home health aide; and
- physical, speech, and occupational therapy (services provided as part of home health are not subject to separate visit limits for therapy services).

These services are only covered when your condition generally confines you to your home except for brief absences.

**Hospice care services**

Hospice care will be covered, for members diagnosed with a terminal illness with a life expectancy of six months or less. Covered services include the following:

- skilled nursing care, including IV therapy services;
- drugs and other outpatient prescription medications for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the member in order to provide the member’s primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days;
- physical, speech, or occupational therapy (services provided as part of hospice care are not subject to separate visit limits for therapy services);
- durable medical equipment;
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling with respect to the member’s care and death; and
- bereavement counseling for immediate family members both before and after the member’s death.

**Hospital services**

Your coverage includes medically necessary ambulance services. In an emergency, HealthKeepers authorization is not required. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life.

Your coverage provides benefits for the hospital and doctors' services when you are treated on an outpatient basis, or when you are an inpatient because of illness, injury, or pregnancy. (See Maternity later in this section for an additional discussion of pregnancy benefits.) Your benefits include coverage for medically necessary care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services.

In addition to your semi-private room, general nursing services and meals, your coverage includes maximum allowed amounts for medically necessary services and supplies furnished by the hospital when prescribed by HealthKeepers physicians.
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While you are an inpatient in the hospital, you have coverage for the medically necessary services rendered by HealthKeepers physicians and other HealthKeepers providers.

Note: All non-emergency inpatient hospital stays must be approved in advance, except hospital stays for vaginal or cesarean deliveries without complications.

Private room
Your inpatient hospital benefits include a stay in a semi-private room unless a private room is approved in advance by HealthKeepers. We will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your inpatient benefits will cover the hospital's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your copayment and coinsurance (if any).

Infusion services
When authorized by HealthKeepers, we cover infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

Note: Infusion services may be received at multiple sites of service, including facilities, professional provider offices, ambulatory infusion centers and from home infusion providers. Benefits may vary by place of service, and where you choose to receive covered services may result in a difference in your copayment and/or coinsurance. Please see the Infusion services section on the Summary of benefits for a description of the benefits by place of service.

Lymphedema
Your coverage includes benefits for expenses incurred in connection with the treatment of lymphedema.

Maternity
Prenatal and newborn care
If the subscriber or subscriber's dependent becomes pregnant, HealthKeepers provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered.

Your benefits include:
- home setting covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital stay;
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- home care services for postnatal care;
- circumcision of a covered male dependent;
- services for interruption of pregnancy;
- use of the delivery room and care for normal deliveries; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.
Future Moms
A subscriber or subscriber’s covered dependent is eligible to participate in Future Moms. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A Future Moms consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. As soon as pregnancy is confirmed, sign up for the program by calling 800-828-5891. You will receive:
- a kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- a risk appraisal to identify signs of premature labor; and
- after delivery, a birth kit and child care book.

Note: See If your family changes in the Changing your coverage section for details on when and how to enroll a newborn.

Medical equipment (durable)
We cover the rental (or purchase if that would be less expensive) of medical equipment (durable) when obtained from a HealthKeepers medical equipment (durable) provider. Also covered are maintenance and necessary repairs of medical equipment (durable) except when damage is due to neglect.

Examples of covered medical equipment (durable) include:
- nebulizers;
- hospital type beds;
- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

Medical devices and appliances
We cover the cost of fitting, adjustment, and repair of the following items when prescribed for activities of daily living:

Examples of covered medical devices include:
- orthopedic braces;
- leg braces, including attached or built-up shoes attached to the leg brace;
- molded, therapeutic shoes for diabetics with peripheral vascular disease;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints

Medical formulas
We cover special medical formulas which are the primary source of nutrition for members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.
Medical supplies and medications
Your coverage includes benefits for medical supplies and medications. Examples of medical supplies include:
- hypodermic needles and syringes;
- allergy serum;
- oxygen and equipment (respirators) for its administration; and
- non-injectable prescription medications provided by your doctor.

Injectable medications
Your coverage includes benefits for self-administered injectable medications obtained through a retail pharmacy or administered by a HealthKeepers provider. Please see “Prescription drugs administered by a medical provider” and “Prescription drug benefit at a retail or home delivery (mail order) pharmacy” at the end of What is Covered for detailed information.

Prosthetic devices and components
Your coverage includes benefits for prosthetic devices. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot, or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

Mental health or substance use disorder treatment
Accessing your mental health services and substance use disorder services (treatment of alcohol or drug dependency) is easy. In fact, you have a dedicated department available to you simply by calling 800-991-6045. All members can select any mental health and substance use disorder provider listed in your provider directory. Or if you are unsure of which provider to see, call 800-991-6045 and the representative will be able to match you with a provider who seems best suited to meet your needs.

Covered services include the following:

- **Inpatient services** in a hospital or any facility that we must cover per state law. Inpatient benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient’s diagnosis and treatment, electroconvulsive therapy, detoxification, and rehabilitation.

- **Outpatient services** including office visits and treatment in an outpatient department of a hospital or outpatient facility, such as partial hospitalization programs and intensive outpatient programs. Covered services include individual psychotherapy, group psychotherapy, psychological testing and medication management visits (visits to your physician to make sure that the medication you are taking for a mental health or substance use disorder is working and the dosage is right for you).

- **Residential treatment** which is specialized 24-hour treatment in a licensed residential treatment center or intermediate care facility. It offers individualized and intensive treatment and includes:
  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, and education.

You can get covered services from the following providers:
- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

**Obstetrician-gynecologist physician services**

All female members may receive services from an obstetrician-gynecologist who is a HealthKeepers physician for the care of or related to the female reproductive system and breasts. The obstetrician-gynecologist must obtain authorization from HealthKeepers for inpatient hospital services and outpatient surgery.

**Skilled nursing facility stays**

The following items and services will be provided to you as an inpatient in a skilled nursing bed of a HealthKeepers provider skilled nursing facility or in a skilled nursing bed in a HealthKeepers provider hospital:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.

Your inpatient skilled nursing facility benefits include a stay in a semi-private room unless a private room is approved in advance by HealthKeepers. We will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your inpatient benefits would cover the skilled nursing facility’s charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your copayment and coinsurance (if any).

Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice care.

**Spinal manipulation and manual medical therapy service**

Your coverage includes spinal manipulation and manual medical therapy services when performed by a provider within the American Specialty Health Group (ASHG). Covered services include examination, re-examination, manipulation, conjunctive therapy, radiology, durable medical equipment, and laboratory tests related to the delivery of these services.

To receive care, please visit our website at www.anthem.com, or contact ASHG directly for a list of ASHG providers. Then, simply contact a participating ASHG provider to make an appointment. The ASHG provider is responsible for obtaining authorization prior to providing care.
Out-of-plan
If you wish to receive care from a non-ASHG provider, contact ASHG directly for authorization. If authorization is not received, you will be responsible for all costs related to these services.

Questions concerning ASHG providers may be directed to ASHG’s network department at 800-972-4226. Questions concerning coverage may be directed to ASHG’s customer service department at 800-678-9133. Both departments are open 9:00 a.m. to midnight, Eastern Standard Time, Monday-Friday, and noon to 8:00 p.m. Eastern Standard Time, Saturday-Sunday.

Surgery

General surgery
Your coverage includes benefits for surgery services when approved in advance by HealthKeepers and when treatment is received at an inpatient, outpatient, or ambulatory surgery facility, or doctor's office. We will not pay separately for pre- and post-operative services.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.
Benefits are limited to certain oral surgeries including:
- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and is medically necessary to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “dental services” section.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Organ and tissue transplants, transfusions
We cover organ and tissue transplants and transfusions. When a covered human organ or tissue transplant is provided from a living donor to a member, both the recipient and the donor may receive the benefits of this EOC.

Note: Certain organ or tissue transplants are considered experimental/investigative or not medically necessary. Coverage for organ and tissue transplants is determined through the pre-authorization process.

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.
To maximize your benefits, you should call our transplant department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant.

Reconstructive breast surgery
Mastectomy, or the surgical removal of all or part of the breast, is a covered service. Also covered are:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and
- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the member.

Therapy

Cardiac rehabilitation therapy
Your coverage includes benefits for cardiac rehabilitation which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy
Your coverage includes benefits for the treatment of disease by chemical or biological antineoplastic agents.

Physical, occupational and speech therapy
Your coverage includes benefits for short-term physical, occupational, and speech therapy when the treatment is medically necessary for your condition. In the judgment of HealthKeepers, short-term rehabilitative therapy services can be expected to result in significant improvement of your condition within 90 consecutive days of beginning outpatient treatment. Refer to your Summary of benefits for limitations, copayment and coinsurance amounts.

Physical therapy is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for physical therapy to treat lymphedema.

Occupational therapy is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed and bathing.

Speech therapy is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly or prior medical treatment.

Note: Long term therapy or rehabilitative care is excluded unless otherwise specified in this EOC as covered under Early Intervention Services.

Radiation therapy
Your benefits include radiation therapy including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.
Respiratory therapy
Your benefits include respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Vision correction after surgery or accident
In situations such as those defined below, your coverage includes the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
  - contact lenses are used for the treatment of infantile glaucoma;
  - corneal or scleral lenses are prescribed in connection with keratoconus;
  - scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
  - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Wellness services
Your coverage provides for preventive care services for children, adolescents and adults. Preventive care services generally include check-up visits, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance.

Services are covered as preventive care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, but instead benefits will be considered under the diagnostic services benefit.

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and your HealthKeepers provider performs additional necessary covered services, these services will generally be covered as diagnostic and/or surgical services and not as preventive care services. Also, covered screenings that you undergo because you have a personal or family history of a particular condition are not generally covered as preventive care services. Deductibles, copayments, and coinsurance amounts applicable to diagnostic and/or surgical services may be different from those applicable to preventive care services. Please see the Diagnostic tests and Surgery sections on the Summary of benefits for more information.

The preventive care services in this section meet the requirements outlined under federal and state law. Preventive care services covered by your health plan that meet these requirements are not subject to cost shares (for example, deductible, copayment, and/or coinsurance amounts) when services are received from HealthKeepers providers. That means HealthKeepers pays 100% of the maximum allowed amount. Cost
shares will apply when services are received from non-HealthKeepers providers. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High blood pressure;
   - Type 2 diabetes mellitus;
   - Cholesterol;
   - Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
   - Women’s contraceptives including all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, and counseling. Contraceptive coverage includes generic and single-source brand drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Standard multi-source brand drugs will be covered under the prescription drug benefit.
   - Breastfeeding support, supplies, and counseling. Standard benefits for breast pumps are limited to one pump per pregnancy.
   - Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
   - Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of pap smear results.
   - Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.
   - Screening and counseling for interpersonal and domestic violence.
   - Well women visits.

5. Counseling services related to general nutrition, and to smoking and tobacco use cessation.

You may call Member Service at 800-582-6941 for additional information about these services or view the federal government websites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov

In addition to the Federal requirements above, preventive coverage also includes the following covered services at intervals no less frequent than as required by state law:

- Routine screening mammograms
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- Routine annual Pap tests including coverage for testing performed by any FDA-approved gynecologic cytology screening technologies;
- Routine annual prostate specific antigen testing and digital rectal exams for male enrollees age 40 and older.

Wigs
Your coverage includes benefits for a wig when needed to replace scalp hair following an illness or injury. Benefits are limited to one wig per member per calendar year maximum shown on the Summary of benefits, and are available despite the exclusion in the plan of benefits for, or related to, cosmetic surgery or procedures.

Prescription drugs administered by a medical provider

Your plan covers prescription drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient facility. This includes drugs for infusion therapy, chemotherapy, specialty drugs, blood products, and office-based injectables that must be administered by a provider. This section applies when your provider orders the drug and administers it to you.

Benefits for drugs that you inject or get at a pharmacy (i.e., self-administered injectable drugs) are not covered under this section. Benefits for those drugs are described in the “Prescription drug benefit at a retail or home delivery (mail order) pharmacy” section that follows.

Note: When prescription drugs are covered under this benefit, they will not also be covered under the “Prescription drug benefit at a retail or home delivery (mail order) pharmacy” benefit. Also, if prescription drugs are covered under the “Prescription drug benefit at a retail or home delivery (mail order) pharmacy benefit, they will not be covered under this benefit.

Important details about prescription drug coverage

Your plan includes certain features to determine when prescription drugs should be covered, which are described below. As part of these features, your prescribing doctor may be asked to give more details before we can decide if the drug is medically necessary. We may also set quantity and/or age limits for specific prescription drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or pharmacy and therapeutics process.

Prior authorization

Prior authorization may be needed for certain prescription drugs to make sure proper use and guidelines for prescription drug coverage are followed. We will contact your provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your provider.

If prior authorization is denied you have the right to file a grievance as outlined in the “Grievance/appeal and eternal review procedures” section of this EOC.

For a list of drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a drug or related item on the list does not promise coverage under your plan. Your provider may check with us to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic drugs are covered under the plan.
Step therapy
Step therapy is a process in which you may need to use one type of drug before we will cover another. We check certain prescription drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective prescription drugs. If a doctor decides that a certain drug is needed, prior authorization will apply.

Therapeutic substitution
Therapeutic substitution is an optional program that tells you and your doctors about alternatives to certain prescribed drugs. We may contact you and your doctor to make you aware of these choices. Only you and your doctor can determine if the therapeutic substitute is right for you. We have a therapeutic drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Prescription drug benefit at a retail or home delivery (mail order) pharmacy
Your plan also includes benefits for prescription drugs you get at a retail or mail order pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of retail pharmacies, a home delivery (mail order) pharmacy, and a specialty pharmacy. The PBM works to make sure drugs are used properly. This includes checking that prescriptions are based on recognized and appropriate doses and checking for drug interactions or pregnancy concerns.

Note: Benefits for prescription drugs, including specialty drugs, which are administered to you in a medical setting (e.g., doctor’s office, home care visit, or outpatient facility) are covered under the “Prescription drugs administered by a medical provider” benefit. Please read that section for important details.

Prescription drug benefits
As described in the “Prescription drugs administered by a medical provider” section, prescription drug benefits may depend on reviews to decide when drugs should be covered. These reviews may include prior authorization, step therapy, use of a prescription drug list, therapeutic substitution, day/supply limits, and other utilization services. Your in-network pharmacist will be told of any rules when you fill a prescription, and will be also told about any details we need to decide benefits.

Covered prescription drugs
To be a covered service, prescription drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a prescription. Prescription drugs must be prescribed by a licensed provider and you must get them from a licensed pharmacy.

Benefits are available for the following:
- prescription legend drugs from either a retail pharmacy or the PBM’s home delivery pharmacy;
- specialty drugs;
- self-administered injectable drugs. These are drugs that do not need administration or monitoring by a provider in an office or facility. Office-based injectables and infused drugs that need provider administration and/or supervision are covered under the “Prescription drugs administered by a medical provider” benefit;
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- oral chemotherapy drugs when administration or monitoring by a provider or in an office or facility is not required;
- self-injectable insulin and supplies and equipment used to administer insulin;
- self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the “Preventive care” benefit. Please see that section for more details;
- special food products or supplements when prescribed by a doctor if we agree they are medically necessary;
- flu shots (including administration). These will be covered under the “Preventive care” benefit.
- prescription drugs that help you stop smoking or reduce your dependence on tobacco products. These drugs will be covered under the “Preventive care” benefit;
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a prescription for a member age 18 or older. These products will be covered under the “Preventive care” benefit;
- prescription drugs used to treat sexual or erectile dysfunctions or inadequacies.

We cannot deny prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Additionally, benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Please see “Experimental/investigative” in the “Definitions” section for additional information about the exception criteria and requirements for these coverage situations.

Where you can get prescription drugs

In-network pharmacy
You can visit one of the local retail pharmacies in our network. Give the pharmacy the prescription from your doctor and your Identification Card and they will file your claim for you. You will need to pay any copayment, coinsurance, and/or deductible that applies when you get the drug. If you do not have your Identification Card, the pharmacy will charge you the full retail price of the prescription and will not be able to file the claim for you. You will need to ask the pharmacy for a detailed receipt and send it to us with a written request for payment.

Specialty pharmacy
If you need a specialty drug, you or your doctor should order it from the PBM's specialty pharmacy. We keep a list of specialty drugs that may be covered based upon clinical findings from the pharmacy and therapeutics (P&T) process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's specialty pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about specialty drugs.

When you use the PBM's specialty pharmacy a patient care coordinator will work with you and your doctor to get prior authorization and to ship your specialty drugs to you or your doctor's office. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get a list of covered specialty drugs by calling Member Services at the phone number on the back of your Identification card or check our website at www.anthem.com.

**Home delivery pharmacy**

The PBM also has a home delivery pharmacy which lets you get certain drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your doctor or have your doctor send the prescription to the home delivery pharmacy. Your doctor may also call the home delivery pharmacy. You will need to send in any copayments, deductible, or coinsurance amounts that apply when you ask for a prescription or refill.

A maintenance medication is a drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the prescription drug you are taking is a maintenance medication, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

**Out-of-network pharmacy**

You may also use a pharmacy that is not in our network. You will be charged the full retail price of the drug and you will have to send your claim for the drug to us (out-of-network pharmacies won’t file the claim for you). You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the out-of-network pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- name and address of the out-of-network pharmacy;
- patient’s name;
- prescription number;
- date the prescription was filled;
- name of the drug;
- cost of the drug;
- quantity (amount) of each covered drug or refill dispensed.

You must pay the full retail price of the drug. Reimbursement to you is based on the maximum allowed amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.
Services of non-participating pharmacies
Notwithstanding any provision in this EOC to the contrary, you have coverage for outpatient prescription drug services provided to you by an out-of-network pharmacy that has previously notified the PBM of its agreement to accept reimbursement for its services at rates applicable to in-network pharmacies including any applicable copayment, coinsurance and/or deductible (if any) amounts as payment in full to the same extent as coverage for outpatient prescription drug services provided to you by an in-network provider. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy agreement with the PBM or its designee within thirty days of being requested to do so in writing by the PBM, unless and until the pharmacy executes and delivers the agreement.

What you pay for prescription drugs

Tiers
Your share of the cost for prescription drugs may vary based on the tier the drug is in.

- Tier 1 drugs have the lowest coinsurance or copayment. This tier contains low cost and preferred drugs that may be generic, single source brand drugs, or multi-source brand drugs.
- Tier 2 drugs have a higher coinsurance or copayment than those in Tier 1. This tier contains preferred drugs that may be generic, single source, or multi-source brand drugs.
- Tier 3 drugs have a higher coinsurance or copayment than those in Tier 2. This tier contains non-preferred and high cost drugs. This includes drugs considered generic, single source brands, and multi-source brands.

We assign drugs to tiers based on clinical findings from the pharmacy and therapeutics (P&T) process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier. We will provide at least 30 day prior written notice of any modification to a formulary that results in the movement of a prescription drug to a tier with higher cost-sharing requirements.

Prescription drug list
We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain drugs if they are not on the Prescription Drug List.

The drug list is developed by us based upon clinical findings, and where proper, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, generic drugs, the use of one drug over another by our members, and where proper, certain clinical economic reasons.

We retain the right, at our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as medically necessary.

There are two exceptions to the formulary requirement:
• You may obtain coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if we determine, after consultation with the prescribing physician, that the formulary drugs are inappropriate for your condition.

• You may obtain coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if:
  o You have been taking or using the non-formulary prescription drug for at least six months prior to its exclusion from the formulary; and
  o The prescribing physician determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

Additional features of your prescription drug pharmacy benefit

Day supply and refill limits
Certain day supply limits apply to prescription drugs as listed in the Summary of benefits. In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your Identification Card.

Special programs
From time to time we may offer programs to support the use of more cost-effective or clinically effective prescription drugs including generic drugs, home delivery drugs, over the counter drugs or preferred products. Such programs may reduce or waive copayments or coinsurance for a limited time.
What is not covered (Exclusions)

This list of services and supplies are excluded from coverage under this EOC. They will not be covered in any case.

A

Your coverage does not include benefits for **acupuncture**.

Your coverage does not include benefits for services received which are not **authorized in advance by HealthKeepers**, unless otherwise specified in this EOC.

B

Your coverage does not include benefits for **biofeedback therapy**.

C

Your coverage does not include benefits for over-the-counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, diapers, and ice bags.

Your coverage does not include benefits for, or related to, **cosmetic surgery or procedures**, including complications that directly 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. HealthKeepers will not consider the patient’s mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for the following **dental** or oral surgery services:

- 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;
• treatment of natural teeth due to diseases;
• treatment of natural teeth due to accidental injury, unless you submitted a treatment plan to HealthKeepers for prior approval. No approval of a plan of treatment by HealthKeepers is required for emergency treatment of a dental injury;
• chewing and biting related injuries unless the chewing or biting results from a medical or mental condition;
• 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 in the What is covered section of this EOC.

Your coverage does not include benefits for donor searches for organ or tissue transplants, including compatibility testing of potential donors who are not immediate blood-related family members (parent, child, sibling).

E

Your coverage does not include benefits for services or supplies primarily for educational, vocational, or self management/training purposes, except as otherwise specified in this EOC or when received as a part of covered wellness services.

Your coverage does not include benefits for experimental/investigative procedures as well as services related to or complications that directly result from such procedures except for clinical trials for cancer. The criteria for deciding whether a service is experimental/investigative or a clinical trial cost for cancer as specified in Exhibit A towards the end of this EOC.

F

Your coverage does not include benefits for the following family planning services:

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

Your coverage does not include benefits for services for palliative or cosmetic foot care are including:
• flat foot conditions;
38 - What is not covered

- 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 (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except as treatment for patients with diabetes or vascular disease);
- care of toenails (except as treatment for patients with diabetes or vascular disease);
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

G

Your coverage does not include services for surgical treatments of **gynecomastia** for cosmetic purposes.

H

Your coverage does not include benefits for **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.

Your coverage does not include benefits for **hearing aids** or for examinations to prescribe or fit hearing aids, unless otherwise specified in the **EOC**.

Your coverage does not include benefits for the following **home care services**:
- homemaker services (except as rendered as part of hospice care);
- maintenance therapy;
- food and home delivered meals; or
- custodial care and services.

Your coverage does not include benefits for the following **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; or
- a private room unless it is **medically necessary** and approved by **HealthKeepers**.
Your coverage does not include benefits for **immunizations** required for travel and work, unless such services are received as part of the covered preventive care services as defined in the **What is covered** section of this EOC.

**M**

Your coverage does not include benefits for **medical equipment (durable), appliances, devices, and supplies** that have both a non-therapeutic and therapeutic use. These include but are not limited to:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens, bed boards;
- 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; or
- repair or replacement of equipment you lose or damage through neglect.

Your coverage does not include benefits for **medical equipment (durable)** that is not appropriate for use in the home.

Your coverage does not include benefits for services or supplies deemed not **medically necessary** by HealthKeepers at its sole discretion. Notwithstanding this exclusion, all wellness services and hospice care services described in this EOC are covered. This exclusion shall not apply to services you receive on any day of **inpatient** care that is determined by 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 such as reviewing patient status, test results, and patient medical records. **Inpatient** evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by a pathologist, radiologist, or anesthesiologist 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.

Nothing in this exclusion shall prevent a **member** from appealing HealthKeeper’s decision that a service is not **medically necessary**.

Your coverage does not include benefits for the following **mental health services and substance use disorder**:

- **inpatient stays** for environmental changes;
- cognitive rehabilitation therapy;
- educational therapy;
What is not covered

- vocational and recreational activities;
- coma stimulation therapy;
- services for sexual deviation and dysfunction;
- treatment of social maladjustment without signs of a psychiatric disorder; or
- remedial or special education services.

Your coverage does not include benefits for nutrition counseling and related services, except when provided as part of diabetes education, for the treatment of an eating disorder, or when received as a part of covered wellness services.

Your coverage does not include benefits for nutritional and/or dietary supplements, except as provided under this EOC 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...

Your coverage does not include benefits for services and supplies related to obesity or services 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.

Your coverage does not include benefits for organ or tissue transplants, including complications caused by them, except as outlined in the What is covered section of this EOC.

Your coverage does not include benefits for paternity testing.

Your coverage does not include benefits for 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 services.
Your coverage does not include benefits for **services, supplies, or devices** if they are:

- not listed as covered under this EOC;
- not prescribed, performed, or directed by a provider licensed to do so;
- services received from providers not licensed by law to provide *covered services* defined in this EOC. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers;
- received before the effective date or after a member's coverage ends;
- telephone consultations, charges for not keeping appointments, charges for completing claim forms, or other such charges;
- 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; or
- benefits for charges from stand-by physicians in the absence of covered services being rendered.

Your coverage does not include benefits for **services or supplies** if they are provided or available to a member:

- 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 benefit plans offered to either civilian employees or retired civilian employees of the federal or state government.
- 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 EOC have been paid.

This exclusion applies whether or not the member waives his or her rights under these laws, amendments, programs or terms of employment. However, HealthKeepers will provide the *covered services* specified in this EOC when benefits under these programs have been exhausted.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which you would not have been charged if you did not have health care coverage. **Your coverage does not include benefits for**:

- amounts above the *maximum allowed amount* for a service;
- penile implants; or
- neurofeedback and related diagnostic tests.

Your coverage does not include benefits for services for **sex transformation or sexual dysfunction**, This includes medical and mental health services.

Your coverage does not include benefits for the following **skilled nursing facility** stays:

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

Your coverage does not include benefits for **smoking cessation** programs not affiliated with us.
Your coverage does not include benefits for the following spinal manipulation and manual medical therapy services:

- any treatment or service not authorized by ASHG;
- services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjuective 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 or in the research state;
- diagnostic scanning, including magnetic resonance imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography;
- educational programs, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing;
- air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; or
- vitamins, minerals, nutritional supplements, or any other similar type products.

Your coverage does not include benefits for the following 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 from birth to age three who qualify for Early Intervention services;
- group speech therapy;
- group or individual exercise classes or personal training sessions; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

Your coverage does not include 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.

Your coverage does not include benefits for the following vision services:

- vision services or supplies unless needed due to eye surgery or accidental injury;
- 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 accompanying frames of any type;
• services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; or
• any other vision services not specifically listed as covered.

W

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

Your coverage does not include benefits for 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. Services will not be covered if you could have received benefits for the injury or disease if you had complied with applicable laws and regulations. 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 member reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.
What’s not covered under your prescription drug retail or home delivery (mail order) pharmacy benefit

In addition to the above exclusions, certain items are not covered under the prescription drug retail or home delivery (mail order) pharmacy benefit:

**Administration charges** - Charges for the administration of any drug except for covered immunizations as approved by us or the PBM.

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

**Contraceptives drugs**, injectable contraceptive drugs and patches unless we must cover them by law.

**Contrary to approved medical and professional standards** - Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

**Delivery charges** - Charges for delivery of prescription drugs.

**Drugs given at the provider’s office/facility** - Drugs you take at the time and place where you are given them or where the prescription order is issued. This includes samples given by a doctor. This exclusion does not apply to drugs used with a diagnostic services, drugs given during chemotherapy in the office, or drugs covered under their medical supplies benefit — they are covered services.

**Drugs not on the Anthem prescription drug list (a formulary)** You can get a copy of this list by calling us or visiting our website at www.anthem.com.

**Drugs that do not need a prescription**. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

**Drugs over quantity or age limits**. Drugs in quantities which are over the limits set by the plan, or which are over any age limits set by us.

**Drugs over the quantity prescribed or refills after one year**. Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.

**Fluoride treatments**, tropical and oral fluoride treatments.

**Infertility drugs**. Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
**Items covered as durable medical equipment (DME).** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit may be covered under the Medical equipment (durable) or Medical supplies benefit. Please see that section for details.

**Items covered as medical supplies -** Oral immunizations and biological, even if they are federal legend drugs, are covered as medical supplies based on where you the service or item. Over-the-counter drugs, devices or products, are not covered services unless we must cover them under federal law.

**Items covered under the medical supplies and medications benefit.** Allergy desensitization products or allergy serum. While not covered under the “Prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy” benefit, these items may be covered under the “Medical supplies and medications” benefit. Please see that section for more details.

**Mail order providers other than the PBM’s home delivery mail order provider.** Prescription drugs dispensed by any mail order provider other than the PBM’s home delivery mail order provider, unless we must cover them by law.

**Non-approved drugs.** Drugs not approved by the FDA.

**Off label use.** The exception to this Exclusion is described in “Covered Prescription Drugs” in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.

**Onychomycosis drugs.** Drugs for onychomycosis (toenail fungus) except when we allow it to treat members who are immune-compromised or diabetic.

**Over-the-counter items.** Drugs, devices and products, or prescription legend drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product. This includes prescription legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over-the-counter products that we must cover under federal law with a prescription.

**Sex change drugs.** Drugs for sex change surgery.

**Sexual dysfunction drugs.** Drugs used to treat sexual or erectile problems.

**Syringes.** Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.

**Weight loss drugs.** Any drug used mainly for weight loss.
Claims and payments

We consider the charge to be incurred on the date a service is provided. This is important because you must be actively enrolled on the date the service is provided. Various limits will be described in the Summary of benefits and this section of the EOC.

Calendar year deductible
Your benefits include a calendar year deductible for certain covered services. Both in-plan and out-of-plan services accumulate toward the calendar year deductible. Before we will make payments for covered services other than in-plan wellness services, you must first satisfy the calendar year deductible. See the Summary of benefits section of this EOC for the amount of your calendar year deductible.

What you will pay
Copayments and coinsurance (if any) for certain covered services are outlined in the Summary of benefits. These amounts are your financial responsibility. Copayments should be paid by or on behalf of the member at the time the covered service is rendered. Applicable deductible and/or coinsurance may also be collected.

Annual limit

Calendar year limit
The Summary of benefits lists the calendar year limit for copayments, coinsurance or deductible (if any). When a member reaches the annual calendar year limit, that member will no longer be required to pay additional copayments, coinsurance or deductible (if any) for the remainder of that calendar year. However, when all members in the same immediate family satisfy their aggregate calendar year limit, no member in that family will be required to pay additional copayments, coinsurance or deductible (if any) for the remainder of that calendar year. When members have reached their calendar year limits, they will be notified by HealthKeepers within 30 days.

The copayments, coinsurance and deductible (if any) for the services listed below are not counted toward the calendar year limit and are never waived. Any copayments, coinsurance or deductible (if any) paid in excess of the calendar year limit, except those which are never waived, will be promptly refunded to you.

What does not count toward this limit
Copayments, coinsurance and deductible (if any) for the following services do not apply toward the annual limit:

- routine vision services for members age 19 and older;

Any charges over HealthKeeper’s maximum allowed amount are not considered copayments or coinsurance and do not apply toward the annual limit.

How HealthKeepers pays a claim
The covered services available under your EOC are to be used only by you and your covered dependents. You may not give permission to anyone else (assign your right) to receive covered services under your coverage.

You may not assign your right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not constitute a waiver of, or otherwise restrict,
HealthKeeper’s right to direct future payments to you or any other individual or facility. Notwithstanding any provision in this EOC to the contrary, however, HealthKeepers:

- will reimburse directly any ambulance service provider to whom the member has executed an assignment of benefits; and
- will reimburse a non-HealthKeepers provider or facility directly for medical screening and stabilization services which were rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act.

How we pay a claim takes into account the maximum allowed amount for the service, the participating status of the provider or facility where you receive services, and your member cost share under your health plan’s benefit design. Each of the components is explained in the sections that follow. For the purposes of these sections, providers also include facilities.

### Maximum Allowed Amount

#### General

This section describes how we determine the amount of reimbursement for covered services. Reimbursement for services rendered by HealthKeepers providers and non-HealthKeepers providers is based on the plan’s maximum allowed amount for the covered service that you receive. The maximum allowed amount for this plan is the maximum amount of reimbursement HealthKeepers will allow for services and supplies:

- that meet our definition of covered services, to the extent such services and supplies are covered under your EOC and are not excluded;
- that are medically necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your EOC.

When you receive covered services from a provider, we will, to the extent applicable, apply processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the maximum allowed amount. Our application of these rules does not mean that the covered services you received were not medically necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, our payment will be based on a single maximum allowed amount for such single procedure code rather than a separate maximum allowed amount for each billed code.

“Per diem amount” means an all inclusive fixed payment amount for each day of admission in an inpatient facility.

### Maximum allowed amount for multiple procedures

When multiple procedures are performed on the same day by the same physician or other healthcare professional, we may reduce the maximum allowed amount for those secondary and subsequent procedures because reimbursement at 100% for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

### Provider Network Status
The maximum allowed amount may vary depending upon whether the provider is a HealthKeepers provider or a non-HealthKeepers provider. A HealthKeepers provider is a provider who is in the HealthKeepers network. For covered services performed by a HealthKeepers provider, the maximum allowed amount for this plan is the rate the provider has agreed with us to accept as reimbursement for the covered services. Because HealthKeepers providers have agreed to accept the maximum allowed amount as payment in full for that service, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay a portion of the maximum allowed amount if you have not met your deductible, copayment or coinsurance if any. Please call Member Services for help in finding a HealthKeepers provider or look on www.anthem.com.

Providers who are not in the HealthKeepers network are non-HealthKeepers providers. When you receive covered services from a non-HealthKeepers provider the maximum allowed amount will be one of the following as determined by us:

1. An amount based on our non-HealthKeepers provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: statewide average reimbursement amounts that HealthKeepers previously has paid for similar claims in the state of Virginia, reimbursement amounts accepted by like/similar providers contracted with HealthKeepers, reimbursement rates accepted by providers under the last network contract in effect with HealthKeepers, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the maximum allowed amount upon the level and/or method of reimbursement used by the CMS, HealthKeepers will update such information, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers’ fees and costs to deliver care, or

4. An amount negotiated by us or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management, or

5. An amount based on or derived from the total charges billed by the non-HealthKeepers provider.

A per diem amount may be used in calculating the maximum allowed amount for inpatient facility services. When calculating these amounts, the charges for non-covered services are subtracted from the per diem amount.

Unlike HealthKeepers providers, non-HealthKeepers providers may send you a bill and collect for the amount of the provider’s charge that exceeds our maximum allowed amount. You are responsible for paying the difference between the maximum allowed amount and the amount the provider charges. This amount can be significant. Please call Member Services for help in finding a HealthKeepers provider or visit our website at www.anthem.com.

Certain covered services such as medical supplies, ambulance, early intervention services, home care services, private duty nursing, medical equipment, and medical formulas, may be rendered by persons or entities that
are not providers. There may or may not be networks established for these persons or entities. The *maximum allowed amount* for services from these persons or entities will be determined in the same manner as described above for providers. For *prescription drugs* and diabetic supplies rendered by a pharmacy, the *maximum allowed amount* is the amount determined by us using prescription drug cost information provided by our pharmacy benefits manager.

**Member cost share**

For certain *covered services* and depending on your plan design, you may be required to pay a part of the *maximum allowed amount* as your cost share amount (for example, *deductible, copayment, and/or coinsurance*).

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an in-network or out-of-network provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using out-of-network providers. Please see the **Summary of benefits** in this certificate for your cost share responsibilities and limitations, or call Member Services to learn how this plan's benefits or cost share amounts may vary by the type of provider you use.

*HealthKeepers* will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by an in-network or out-of-network provider. Both services specifically excluded by the terms of your policy/plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits. The *maximum allowed amount* for *inpatient facility* services may be based on a per diem. When calculating these amounts, the charges for non-covered services are subtracted from the per diem.

**Claims Review**

We have processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from out-of-plan providers could be balanced billed by the out-of-plan provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

**Non-participating providers and facilities**

If you go to a non-participating provider or facility with the proper authorization, we may choose to pay you or anyone else responsible for paying the bill. We will pay only after we have received an itemized bill or proof of loss and all the medical information we need to process the claim. We reserve the right to pay no more for a service you receive from a non-participating provider or facility than we would have paid a participating provider or facility for the same service.

In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-HealthKeepers provider.

**When you must file a claim**

Most claims will be filed for you by HealthKeepers providers. You may have to file a claim if you receive care out-of-area from a provider who is not an HealthKeepers provider.
In most cases, the HealthKeepers will reimburse you for covered services paid for by you only if a completed claim (including receipt) has been received by the HealthKeepers within 180 days of the date you received such services.

You will have to file a claim if you receive care billed by someone other than a doctor or hospital, or if the provider cannot file a claim for you. To file a claim, follow these 3 steps:

1. Call 800-582-6941 to order a claim form.
2. Complete and sign the claim form. Attach all itemized bills for covered services. Each itemized bill must contain the following:
   - name and address of the person or organization providing services or supplies;
   - name of the patient receiving services or supplies;
   - date services or supplies were provided;
   - the charge for each type of service or supply;
   - a description of the services or supplies received; and
   - a description of the patient's condition (diagnosis).

3. Send the completed claim form and itemized bill(s) to:

   HealthKeepers, Inc.
   Attention: Operations
   P.O. Box 26623
   Richmond, VA 23261-6623

When your claim is processed

Once a claim has been processed, if your portion of the bill is anything other than zero or equal to a flat copayment amount, a paper copy of the Explanation of Benefits (EOB) statement will be mailed to you to explain your responsibility. In the event that your portion of the bill is zero or equal to a flat copayment amount, the paper copy will not be mailed, but will be available to you online at www.anthem.com. If you do not have access to the Internet, you may contact Member Services to arrange for a printed copy.

In processing your claim, HealthKeepers may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the “When you must file a claim” paragraph of this section will be processed within 30 days of receipt of the claim. HealthKeepers may extend this period for another 15 days if HealthKeepers determines it to be necessary because of matters beyond its control. In the event that this extension is necessary, you will be notified prior to the expiration of the initial 30-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, HealthKeepers will make its decision within 2 working days of its receipt of the medical information needed to process the claim.

HealthKeepers may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by you or your provider furnishing the additional information. You or your provider must submit the additional information to HealthKeepers within either 12 months of the date of service or 45 days from the date you were notified that the information is needed, whichever is later. Once your claim has been processed by HealthKeepers, you will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:
• information sufficient to identify the claim involved;
• the specific reason(s) and the plan provision(s) on which the determination is based;
• a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
• a description of HealthKeeper’s appeal procedures and applicable time limits; and
• the availability of, and contact information for, the U.S. Department of Labor’s Employee Benefits Security Administration that may assist you with the internal or external appeals process.

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that HealthKeepers relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to the patient’s medical condition.

**Recovery of overpayments**

HealthKeepers shall have the right to recover any overpayment of benefits from persons or organizations that HealthKeepers has determined to have realized benefits from the overpayment:

• any persons to or for whom such payments were made;
• any insurance company;
• a facility or provider; or
• any other organization.

You will be required to cooperate with us to secure HealthKeeper’s right to recover the excess payments made on your behalf, or on behalf of covered persons enrolled under your family coverage.

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.
When you are covered by more than one health plan

Coordination of benefits ("COB")
Special COB rules apply when you or members of your family have additional health care coverage through other group health plans, including:

- group insurance plans, including other Blue Cross and Blue Shield plans or HealthKeepers plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

If you are enrolled in a qualified high deductible health plan for purposes of the Health Savings Account provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 and Section 223 of the Internal Revenue Code, any other coverage you have must also satisfy the requirements for qualified high deductible health plans, so as not to affect your tax status. In the event of coverage under more than one health plan, please seek the counsel of a tax advisor.

Primary coverage and secondary coverage
When a member is also enrolled in another group health plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. The decision of which coverage will be primary or secondary is made using benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to the HealthKeeper's, the other coverage will be primary.
- If a member is enrolled as the named insured under one coverage and as a dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a member is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the member is enrolled as a child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the calendar year will be the primary.
- Special rules apply when a member is enrolled as a child under two coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or stepparent with custody will be primary. However, if there is a court order that requires one parent to provide for medical expenses for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the calendar year will be primary.

When HealthKeepers provides secondary coverage, we first calculate the amount that would have been payable had HealthKeepers been primary. Then we coordinate benefits so that the combination of the primary plan's payment and the HealthKeeper's payment does not exceed the amount HealthKeepers would have paid had it been primary. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.
The preceding paragraph does not apply to claims for outpatient prescription drugs provided by a pharmacy when Medicare Part D provides the covered person’s primary prescription drug coverage. See the following section for more information.

**How prescription drug benefits are coordinated when Medicare Part D is primary**

If Medicare Part D provides your primary coverage for outpatient prescription drugs provided by a pharmacy, we first calculate the amount that would have been payable had HealthKeepers been primary. We then pay a secondary benefit up to that amount, in order to reduce any amount you had to pay out-of-pocket under Medicare Part D. The benefit we pay is limited to the lesser of the amount you paid out-of-pocket under Medicare Part D or the amount HealthKeepers would have paid if it had been primary.

**Right of recovery provision**

Immediately upon paying or providing any benefit under HealthKeepers, your health plan shall be subrogated to all rights of recovery a member has against any party potentially responsible for making any payment to a member due to a member’s injuries or illness, to the full extent of benefits provided or to be provided by HealthKeepers.

In addition, if a member receives any payment from any potentially responsible party as a result of an injury or illness, your health plan has the right to recover from, and be reimbursed by, the member for all amounts HealthKeepers has paid and will pay as a result of that injury or illness, up to and including the full amount the member receives from all potentially responsible parties. The member agrees that if he/she receives any payment from any potentially responsible party as a result of an injury or illness, he/she will serve as a constructive trustee over the funds. Failure to hold such funds in trust will be deemed a breach of the member’s fiduciary duty to the health plan.

Further, your health plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a member receives from a third party, the third party’s insurer or any other source as a result of the member’s injuries. The lien is in the amount of benefits paid by your health plan for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a member due to a member’s injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers’ compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The member acknowledges that HealthKeepers recovery rights are a first priority claim against all potentially responsible parties and are to be paid to HealthKeepers before any other claim for the member’s damages. HealthKeepers shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to HealthKeepers will result in a recovery to the member which is insufficient to make the member whole or to compensate the member in part or in whole for the damages sustained. It is further agreed that HealthKeepers is not required to participate in or pay court costs or attorney fees to the attorney
When you are covered by more than one health plan

hired by the member to pursue the member’s damage claim.

The terms of this entire right of recovery provision shall apply and HealthKeepers is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the member identifies the medical benefits HealthKeepers provided. HealthKeepers is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The member shall fully cooperate with HealthKeepers efforts to recover its benefits paid. It is the duty of the member to notify HealthKeepers within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the member. The member shall provide all information requested by HealthKeepers or its representative including, but not limited to, completing and submitting any applications or other forms or statements as HealthKeepers may reasonably request. Failure to provide this information shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against the member.

The member shall do nothing to prejudice HealthKeepers recovery rights as herein set forth. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by HealthKeepers.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the member and HealthKeepers agree that HealthKeepers shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The member agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as HealthKeepers may elect. Upon receiving benefits under HealthKeepers, the member hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.
Changing your coverage

Who is eligible for coverage

Subscriber
A subscriber is eligible for coverage if he/she resides or works in the service area and after he/she satisfies the employer’s eligibility requirements. The employer will inform the subscriber of the effective date, which is agreed upon by HealthKeepers and the employer.

The subscriber’s eligible dependents
Eligible dependents include:
• the subscriber’s spouse or the subscriber’s domestic partner;
• children of the subscriber or the subscriber’s domestic partner, who are age 26 or younger which includes:
  • a newborn, natural child of the subscriber or the subscriber’s domestic partner;
  • a child adopted by the subscriber or the subscriber’s domestic partner, or placed with subscriber or the subscriber’s domestic partner for adoption;
  • a stepchild of the subscriber or the subscriber’s domestic partner; and
• any other child for whom the subscriber or the subscriber’s domestic partner has legal guardianship or court-ordered custody.

Your employer may impose special requirements and will inform you of any action you need to take in order to enroll your domestic partner.

The age limit for enrolling children is age 26. Coverage for children will end on the last day of the calendar year in which the children reach age 26.

The age limit does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of intellectual disability, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the subscriber provides proof of handicap and dependence at the time of enrollment.

For the child enrolled prior to reaching the age limit, coverage may continue beyond the age limit if the subscriber provides proof of handicap and dependence within 31 days after he/she reaches the age limit.

You may be asked to provide the HealthKeepers physician’s certification of the dependent’s condition.

Types of coverage
The subscriber’s employer may choose from five enrollment options offered by HealthKeepers. The subscriber may select the enrollment option, chosen by his/her employer, that meets his/her needs. The options are as follows:
• Employee only
• Employee and spouse or domestic partner
• Employee and one child
• Employee and family
• Employee and children

**When you may enroll**

You may enroll:

• **During the initial enrollment period**
  The *subscriber* may enroll any eligible *dependents* by completing a *HealthKeepers* application to be sent to *HealthKeepers* by the employer. No person is eligible to re-enroll in *HealthKeepers* who has coverage terminated as described in Termination for cause in the After Coverage Ends Section.

• **During open enrollment periods approved by HealthKeepers**
  The coverage of people who enroll during the employer's open enrollment period is effective as agreed upon by the employer and *HealthKeepers* in the Group Enrollment Agreement.

• **During a special enrollment period**
  The *subscriber* may have chosen to decline coverage for himself/herself and/or his/her dependents under this health plan when the *subscriber* could have enrolled for it because of coverage under another health plan.

If the *subscriber* declined coverage under this health plan in writing for himself/herself and/or his/her dependents and later the *subscriber* or his/her dependent(s) loses the other coverage, the *subscriber* may enroll in any benefit package under the plan during a special enrollment period. For example, a special enrollment period of 31 days will be allowed if:

- the other health plan coverage was under a COBRA continuation and the continuation period ran out;
- the employer who had been making contributions toward the other health plan coverage stopped making them; or
- there was a loss of eligibility under the other health plan coverage. Eligibility may have been lost due to:
  - divorce;
  - the death of the *subscriber’s* spouse;
  - a reduction in the number of hours of employment;
  - termination of employment for the *subscriber* or *subscriber’s* spouse at another company; or
  - for a dependent, cessation of dependent status.

A special enrollment period of 60 days will be allowed under two additional circumstances:

- if *your* or *your* eligible dependent’s coverage under Medicaid or the Children’s Health Insurance Program (SCHIP) is terminated as a result of loss of eligibility; or
- if *you* or *your* eligible dependent become eligible for premium assistance under a state Medicaid or SCHIP plan.

Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/SCHIP or of the eligibility determination.
If your family changes
Special enrollment periods are also allowed if your family changes. The change may be due to marriage, the birth of a child, or the placement of a child with you for adoption. Within 31 days after the change occurs, the subscriber will need to complete an application to add dependents or a change form to delete dependents. In all cases, contact the group administrator immediately.

Marriage
The effective date for dependents added as a result of marriage will be determined by the subscriber's employer in accordance with its eligibility requirements.

Newborn dependents
A newborn dependent may be covered from the moment of birth. The subscriber must submit a completed application and the appropriate premium amount, if any, to HealthKeepers within 31 days of the newborn's birth. If an application along with any appropriate premium amount is not received by HealthKeepers within 31 days of birth, the child will not be eligible to be added to the subscriber's coverage until the next open enrollment period.

Adopted dependents
When a child has been placed with a subscriber for adoption, that child is eligible for dependent coverage from the date of the adoption or placement. However, application for coverage must be submitted within 31 days from the date of eligibility, along with proof that the adoption is pending and any appropriate premium amount. If a newborn infant is placed for adoption with the subscriber within 31 days of birth, the child shall be considered a newborn child of the subscriber, and coverage may be effective from the date of the child's birth. If an application, along with any premium amount, is not received by HealthKeepers within 31 days of the adoption or placement for adoption, the child will not be eligible to be added to the subscriber's coverage until the next open enrollment period.

When a dependent is no longer eligible for coverage, the subscriber can change the type of coverage by completing a change form. The effective date of your coverage change will be determined by your employer in accordance with its eligibility requirements.

HealthKeepers may periodically require proof of dependency.

Note: Any dependent, including a newborn child who is not enrolled in HealthKeepers within 31 days after becoming eligible, may not enroll until the employer's next open enrollment period.

Other changes that require notification
Please make sure that HealthKeepers and the subscriber's employer are notified as soon as possible, but no more than 31 days after any of the following changes occur:

- change in name, address or phone number;
- change in subscriber's employment;
- member permanently moves outside the service area;
- death of a member; or
- coverage under another health plan is obtained.

Failure to provide proper notice of these changes in coverage may affect your coverage. HealthKeepers is not responsible for lapses in coverage due to the subscriber's failure or your employer's failure to provide proper notice of a change in coverage.
In the absence of fraud, all statements made by a subscriber shall be considered representations and not warranties.

No statement shall be the basis for voiding coverage or denying a claim after the EOC has been in force for two years from its effective date, unless the statement was material to the risk and contained in a written application.
After coverage ends

All rights to benefits, including inpatient services, shall cease as of the effective date of termination.

Termination for cause

If the subscriber's coverage is terminated for cause, the coverage for all dependents is terminated as well. Eligibility for other insurance coverage must be determined by the employer if HealthKeepers's coverage is terminated for cause. The conditions under which your HealthKeepers coverage may be terminated for cause are as follows:

a. If you allow someone to use your identification card or you use another member's card HealthKeepers may recall the card and terminate your coverage upon 31 days written notice.

b. You represent that all information contained in applications, questionnaires, forms, or statements submitted HealthKeepers is true, correct, and complete, and if you furnished incorrect or incomplete information which constitutes a material misrepresentation, then your coverage may be terminated upon written notice. Members terminated for this reason will be responsible to pay charges for all services provided to the member that are related to this incorrect or incomplete information.

c. If you are guilty of fraud, gross or repeated misbehavior, including but not limited to, abusive behavior to HealthKeepers providers and HealthKeepers administrative personnel in applying for or seeking any benefits under this EOC, then HealthKeepers may terminate your coverage upon 31 days written notice.

d. When, after reasonable efforts (including changing physicians), you cannot establish or maintain a satisfactory physician-patient relationship with your PCP HealthKeepers may terminate your coverage upon 31 days written notice. Evidence of an unsatisfactory physician-patient relationship may include your refusal to accept procedures or treatment recommended by your PCP. When a HealthKeepers physician regards such refusal as incompatible with the continuance of the physician-patient relationship and as obstructing the provision of proper medical care HealthKeepers may terminate your coverage and disclaim all financial responsibility for any further covered service costs incurred by you.

Termination for loss of eligibility

Subject to the conversion privileges listed below, the member's coverage will cease on the date determined by the subscriber's employer in accordance with its eligibility requirements. In the event of the subscriber's death, coverage will terminate for covered dependents of the subscriber on the last day of the period for which payments have been made by or on behalf of the subscriber, subject to the conversion privileges described below.

Termination for employer default

Only members for whom the stipulated payment is actually received by HealthKeepers shall be entitled to covered services and then only for the period for which such payment is received. If payment is not made in full by the employer on or prior to the premium due date, as specified in the agreement, a grace period shall be granted to the employer for payment. We will allow employers a 31 day grace period to pay monthly premiums, except for the first month's premium. During the grace period, coverage shall remain in effect, unless the employer has given HealthKeepers written notice of discontinuance in accordance with the terms of the agreement and in advance of the date of discontinuance. If payment is
not made within the grace period HealthKeepers may cancel coverage as of the end of the grace period or 15 days from the date written notice of termination is provided by HealthKeepers to the employer, whichever is later.

Termination of the agreement
If the agreement between HealthKeepers and the employer is terminated, coverage shall terminate for all subscribers and dependent members as of the effective date of termination of the agreement. All rights to benefits shall cease as of the effective date of termination. There is one exception. Members who become totally disabled while enrolled under this EOC and who continue to be totally disabled as of the date of termination of the agreement may continue their coverage for 180 days, until the member is no longer totally disabled, or until such time as a succeeding carrier elects to provide replacement coverage without limitation as to the disabling condition, whichever period is the shortest. Such members will be responsible for paying the applicable premiums to HealthKeepers for such continuation of coverage.

Reinstatement
Once your coverage is terminated, re-application is necessary before new coverage can begin. Note that if your coverage is terminated for cause as specified above, you are not eligible for reinstatement.

Continuing coverage when eligibility ends
A subscriber and enrolled dependents may be eligible for continuous group coverage or twelve-month continuation.

Continuation of coverage (COBRA)
This section pertains to you only if your employer's group health plan is subject to the requirements of the COBRA law. It generally explains when COBRA continuation coverage may be available to you and your enrolled family members and what you need to do to protect your family's COBRA rights.

COBRA continuation is a temporary extension of coverage. You and your enrolled family members may be qualified beneficiaries. A qualified beneficiary is eligible for COBRA continuation if coverage would ordinarily end due to a qualifying event described in this section. Qualified beneficiaries who elect COBRA coverage must pay the full cost for it, without contribution from the employer.

A covered person will become a qualified beneficiary if he or she loses coverage because one of the following qualifying events occurs:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You die;
- You become entitled to Medicare benefits;
- You become divorced or legally separated;
- For a covered child, he or she stops being an eligible dependent (for example, by attaining the maximum age for coverage); or
- For covered retirees and their covered family members only, the employer files a proceeding in bankruptcy.

COBRA continuation will be offered only after the plan administrator has been notified that a qualifying event has occurred. The employer will notify the plan administrator unless the qualifying event is your
divorce or legal separation or the loss of a covered child’s eligibility. For these qualifying events, you must notify the plan administrator within 60 days after the qualifying event. The form and content of all COBRA-related notices must satisfy your employer’s requirements. Contact your group administrator for instructions.

After receiving timely notice, the plan administrator will inform the qualified beneficiaries of their right to elect continuation of coverage and of:

- the monthly cost for the coverage;
- the due date of each monthly payment; and
- where the monthly payments should be sent.

Qualified beneficiaries have 60 days in which to elect COBRA continuation using forms that have been approved by HealthKeepers and supplied by the plan administrator. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA on behalf of your covered spouse, and parents may elect it on behalf of their covered children.

Within 45 days after electing COBRA, the first payment for the coverage must be paid in full, along with any unpaid amounts necessary to pay for coverage through the current month. Thereafter, monthly payments must be made according to the instructions provided by the plan administrator.

When the qualifying event is:

- your death, divorce, legal separation or Medicare entitlement or an enrolled child’s loss of eligibility, continuation coverage may last up to 36 months.
- a reduction in your work hours or your termination of employment, continuation coverage may last up to 18 months. However, if you became entitled to Medicare less than 18 months before one of these qualifying events, continuation coverage may last up to 36 months after the date of Medicare entitlement for qualified beneficiaries other than you.

If a qualified beneficiary would ordinarily be eligible for 18 months of continuation coverage, that period may be extended for up to 11 additional months if he or she is determined by the Social Security Administration to have been disabled at some time during the first 60 days of COBRA coverage. To be eligible for the 11-month extension, notice must be provided to the plan administrator:

- within 60 days after the date of the Social Security Administration’s disability determination;
- and
- before the end of the first 18 months of COBRA coverage.

Other enrolled non-disabled family members of the disabled qualified beneficiary are also entitled to the 11-month extension if these requirements are met.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your enrolled spouse and child(ren) can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if:

- notice of the second qualifying event is properly given to the plan administrator; and
- the qualifying event would have caused the spouse or child(ren) to lose coverage under your health plan had the first qualifying event not occurred.
After coverage ends

If you have a newborn child, adopt a child, or have a child placed with you for adoption during your COBRA continuation period, that child will also be a qualified beneficiary with COBRA rights. For adding a child or making other changes in dependent coverage, please follow the procedures explained earlier in this booklet.

A qualified beneficiary’s eligibility for COBRA coverage will end on the earliest of the following dates:
- the date that ends the maximum continuation period described above;
- the date that ends the last period for which a monthly payment was made when due;
- the date the qualified beneficiary obtains coverage under any other group health plan that does not contain an exclusion or limitation that is applicable to his or her pre-existing conditions;
- the date the qualified beneficiary becomes enrolled in Medicare; or
- the date the employer’s group health plan ends.

Once eligibility for COBRA coverage ends, the former qualified beneficiary may enroll under any individual program offered by us for which he or she is eligible as explained below.

In order to protect your family’s COBRA rights, you must keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

If you have any questions, please contact the plan administrator. For additional information, you may also contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of EBSA offices are available on EBSA’s website.

Other coverage options besides COBRA continuation coverage
Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.
Important information about your coverage

In the event you need to contact someone about this coverage for any reason please contact your agent. If no agent was involved in the sale of this health maintenance organization coverage, or if you have any additional questions you may contact HealthKeepers, Inc. at the following address and telephone number:

Address:
HealthKeepers, Inc.
Attention: Member Services
P.O. Box 26623
Richmond, VA 23261-6623

Telephone:
800-582-6941

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, HealthKeepers, Inc., or the Bureau of Insurance, have your contract number ready.

We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other actions.

Statement of ERISA rights
As a participant in your plan you may be entitled to certain rights and protections under applicable portions of the Employee Retirement Income Security Act (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights and protections may include the following:

If you are entitled to ERISA rights you may examine, without charge, at the plan administrator's office and at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by your plan with the Department of Labor (such as detailed annual reports), and plan descriptions.

You may obtain copies of all plan documents and other plan information by writing to the plan administrator. The plan administrator may make a reasonable charge for the copies.

Note: ERISA generally does not apply to church plans or to government plans (such as plans sponsored by city, county, or state governments, or by public school systems).

Plan "fiduciaries"
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants.
Important information about your coverage

- No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial.
- You have the right to have the plan administrator review and reconsider your claim.

Enforcement of ERISA rights

Under ERISA, there are steps to enforce the above rights. For instance:

- If you request materials to which you are entitled from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials (unless the materials were not sent because of reasons beyond the control of the Administrator).
- If you have a claim for benefits or an appeal of a coverage decision, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court decides who pays court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim to be frivolous.

Assistance

If you have questions about your plan, contact your plan administrator. If you have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Changes in your HealthKeepers

HealthKeepers may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of coverage under this EOC. Any provision, term, benefit, or condition of coverage and this EOC may be amended, revised, or deleted in accordance with the terms of the agreement between HealthKeepers and the employer. This may be done without the member’s consent or concurrence.

Notice in writing

From HealthKeepers to you. A notice sent to you by HealthKeepers is considered “given” when received by the subscriber’s employer at the address listed in HealthKeeper’s records or, if sent directly to you, the notice is considered “given” when mailed to the subscriber’s last known address as shown in HealthKeeper’s enrollment records. Notices include any information which HealthKeepers may send you, including identification cards.
From you or your employer to HealthKeepers, Notice by you or the subscriber’s employer is considered “given” when actually received by HealthKeepers. HealthKeepers will not be able to act on this notice unless the subscriber’s name and identification number are included in the notice.

Grievance/appeal and external review procedures
We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

Complaint Process
Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of HealthKeeper’s receipt of your complaint. If HealthKeepers is unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. HealthKeepers will then respond to you within an additional 30 calendar days. Written complaints may be filed to the following address:

HealthKeepers, Inc.
Attention: Grievances and Appeals
P.O. Box 26623
Richmond, VA 23261-6623

Grievance/appeal process
HealthKeepers is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions you find unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. There are two types of appeals. Internal appeals are requests to reconsider rescissions or coverage decisions of pre-service or post-service claims. Expedited appeals are made available when the application of the time period for making pre-service or post-service appeal decisions could seriously jeopardize the patient’s life, health or ability to regain maximum function, or in the opinion of the patient’s physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain.

How to appeal a coverage decision
66 - Important information about your coverage

To appeal a coverage decision (including a rescission), please send a written explanation of why you feel the coverage decision was incorrect. You or your authorized representative acting on your behalf may submit the written explanation. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any comments, documents or information that you feel HealthKeepers should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- in the case of a claim, the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

You may contact Member Services with your appeal at the following:

**For medical and prescription drug or pharmacy issues:**
HealthKeepers, Inc.
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

Telephone:
800-582-6941

You must file your appeal within either 15 months of the date of service or 180 days of the date you were notified of the adverse benefit determination, whichever is later.

**How HealthKeepers will handle your appeal**
In reviewing your appeal, HealthKeepers will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will resolve and respond in writing to your appeal within the following time frames:

- For pre-service claims, we will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims and rescissions, we will respond in writing within 60 days after receipt of the request to appeal; or
• For expedited appeals, we will respond to you and your provider as soon as possible taking into account your medical condition, but not later than 72 hours from receipt of the request.

We will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination based on new or additional rationale, we will provide you, free of charge, with the rationale.

When our review of your appeal has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

• reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
• any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
• the explanation of the scientific or clinical judgment as it relates to the patient’s medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
• the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant’s adverse decision, whether or not the advice was relied upon.

External review
If the outcome of the appeal is adverse to you, you may be eligible for an independent external review pursuant to federal law.

You must submit your request for external review to us within four (4) months of the notice of your final adverse determination.

A request for external review must be in writing unless we determine that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted as part of the internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact us at the number shown on your identification card and provide at least the following information:

• the identity of the claimant;
• The date (s) of the medical service;
• the specific medical condition or symptom;
• the provider’s name;
• the service or supply for which approval of benefits was sought; and
• any reasons why the appeal should be processed on a more expedited basis.
All other requests for external review should be submitted in writing unless we determine that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Address:
HealthKeepers, Inc.
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279
Telephone:
804-358-7390
in Richmond
800-421-1880
from outside Richmond

Your decision to seek external review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

**Requirement to file an appeal before filing a lawsuit**

You must exhaust the plan's internal appeals procedure (but not an external review) before filing a lawsuit or taking other legal action of any kind against the plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

The plan reserves the right to modify the policies, procedures and time frames in this section upon further clarification from Department of Health and Human Services and Department of Labor.

**Limitations of damages**

In the event a member or his representative sues HealthKeepers, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this EOC, the damages shall be limited to the amount of the member's claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This EOC does not provide coverage for punitive damages, or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and shall not be construed, to affect in any manner any recovery by a member or his representative of any non-contractual damages to which a member or his representative may otherwise be entitled.

**Time limits on legal action**

No action at law or suit in equity shall be brought against HealthKeepers more than one year after the date the cause of action first accrued with respect to any matter relating to:

- this EOC;
• HealthKeeper’s performance under this EOC; or
• any statements made by an employee, officer, or director of HealthKeepers concerning the EOC or the benefits available.

The cause of action shall be deemed to have accrued 180 days after HealthKeeper’s initial decision if you do not initiate an appeal pursuant to HealthKeeper’s appeal process or an independent external review of an adverse utilization review decision through the Bureau of Insurance. Otherwise, the cause of action will be deemed to have accrued after the final decision of HealthKeepers or Bureau of Insurance external review process.

HealthKeeper's continuing rights
On occasion, we may not insist on your strict performance of all terms of this EOC. This does not mean we waive or give up any future rights we have under this EOC.

The HealthKeeper's relationship to providers
The choice of a HealthKeepers provider is solely the member's. HealthKeepers providers are neither employees or agents of HealthKeepers. We can contract with any appropriate provider or facility to provide services to you. Our inclusion or exclusion of a provider or a covered facility is not an indication of the provider's or facility's quality or skill. We make no guarantees about the health of any HealthKeepers providers. We do not furnish covered services, but only make payment for them when received by members.

We are not liable for any act or omission of any HealthKeepers provider, nor are we responsible for a HealthKeepers provider's failure or refusal to render covered services to a member.

Special limitations
The rights of members and obligations of HealthKeepers are subject to the following special limitations: To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of HealthKeepers results in the facilities, personnel, or financial resources of HealthKeepers being unavailable to provide or arrange for the provision of covered services, HealthKeepers shall make a good faith effort to provide or arrange for the provision of such health services taking into account the impact of the event. In such an event, HealthKeepers and HealthKeepers providers shall render covered hospital and medical services insofar as practical, and according to their best judgment. HealthKeepers and HealthKeepers providers shall incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.
Member rights and responsibilities

As a member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we’re committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our network providers and the information you need to make the best decisions for your health and welfare.

**You have the right to:**

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is 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 and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - our company and services.
  - our network of doctors and other health care providers.
  - your rights and responsibilities.
  - the rules of your health care plan.
  - the way your health plan works.
- Make a complaint or file an appeal about:
  - your plan
  - any care you get
  - any covered service or benefit ruling that your plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of your illness, your treatment and what may result from it. If you don’t understand certain information, you can choose a person to be with you to help you understand.

**You have the responsibility to:**

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all plan rules and policies.
- Choose an in-network primary care physician (doctor), also called a PCP, if your health care plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
• Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
• Understand your health problems as well as you can and work with your doctors or other healthcare providers to make a treatment plan that you all agree on.
• Tell your doctors or other health care providers if you don’t understand any type of care you’re getting or what they want you to do as part of your care plan.
• Follow the care plan that you have agreed on with your doctors or health care providers.
• 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 and insurance benefits you have in addition to your coverage with us.
• Let our customer service department know if you have any changes to your name, address or family members covered under your plan.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the booklet and not by this member rights and responsibilities statement.

If you need more information or would like to contact us, please go to anthem.com and select customer support > contact us. Or call the customer service number on your ID card.
Definitions

**Agreement**
is the group enrollment agreement between HealthKeepers and the subscriber's employer, of which this EOC is one part.

**Activities of daily living**
are walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

**Adverse benefit determination**
is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by HealthKeepers.

**Applied behavior analysis**
means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

**Brand name drug**
prescription drugs that the PBM has classified as brand name drugs through use of an independent proprietary industry database.

**Coinsurance**
is the percentage of the maximum allowed amount that you pay for some covered services.

**Copayment**
is the fixed dollar amount you pay for most covered services, such as a doctor's visit.

**Covered services**
are those medically necessary hospital and medical services which are described as covered in this EOC and which are performed, prescribed or directed by a physician.

**Deductible**
is a fixed dollar amount of covered services you pay in a calendar year before HealthKeepers will pay for any remaining services during that calendar year.

**Effective date**
is the date coverage begins for you and/or your dependents enrolled in HealthKeepers.

**Emergency**
is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity; this includes severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Evidence of Coverage (“EOC”)**
is the document that fully explains your health care benefits.

**Experimental/investigative**
is any service or supply that is judged to be experimental or investigative at HealthKeeper's sole discretion. Refer to **Exhibit A** for more information.

**Generic drugs**
prescription drugs that the PMB has classified as generic drugs through use of an independent proprietary industry database. Generic drugs have the same active ingredients, must meet the same FDA rules for safety, purity, and potency, and must be given in the same form (tablet, capsule, cream) as the brand name drug.

**Group administrator**
is the benefits administrator at the subscriber's employer.

**HealthKeepers physician**
is a duly licensed doctor of medicine or osteopathy who has contracted with HealthKeepers to provide medical services to members.

**HealthKeepers provider**
is a medical group, HealthKeepers physician, hospital, skilled nursing facility, pharmacy, or any other duly licensed institution or health professional who has contracted with HealthKeepers or its designee to provide covered services to members. This includes any provider that state law says we must cover (chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist, speech pathologist, certified nurse midwife, marriage and family therapist or licensed acupuncturist) when they give you services that state law says we must cover. A list of HealthKeepers providers is made available to each subscriber prior to enrollment. A current list may be obtained from HealthKeepers upon request and may be seen by visiting HealthKeeper’s website page at www.anthem.com. The list shall be revised by HealthKeepers from time to time as HealthKeepers deems necessary.

**HealthKeepers, we, us, our**
refers to HealthKeepers, Inc.

**High dose**
is a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.
**Home care services**
are services rendered in the home setting. Home care includes services such as skilled nursing visits and physical, speech, and occupational therapy for patients confined to their homes. This also means home infusion services; which is therapy including such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Home infusion therapy does not require that the patient is confined to his/her home.

**Inpatient**
means when you are a bed patient in a hospital.

**Inpatient facilities**
are settings where patients can spend the night, including hospitals, skilled nursing facilities, partial day programs.

**Maintenance medications**
please see the “Prescription drug benefit at a retail or home delivery (mail order) pharmacy” section for details.

**Maximum allowed amount**
is the allowance as determined by HealthKeepers for a specified covered service or the provider's charge for that service, whichever is less.

**Medical director**
is a duly licensed physician or his designee who has been designated by HealthKeepers to monitor the provision of covered services to members.

**Medical equipment (durable)**
is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for activities of daily living purposes.

**Medically necessary**
to be considered medically necessary, a service must:
- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient’s family, or the provider.

**Member**
is any subscriber or enrolled dependent.

**Mental health and substance use disorder**
is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use disorder condition.
Outpatient
refers to a person receiving care in a setting such as a hospital outpatient department, emergency room, professional provider's office, or your home.

Outpatient mental health services
are for the diagnosis and treatment of psychiatric conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Partial day services
include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance abuse, or an intensive outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence. Partial day services are used as an alternative to inpatient treatment.

Pharmacy
a place licensed by state law where you can get prescription drugs and other medicines from a licensed pharmacist when you have a prescription from your doctor.

Pharmacy and Therapeutics (P&T) Process
a process to make clinically based recommendations that will help you access quality, low cost medicines within your plan. The process includes health care professionals such as nurses, pharmacists, and doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Plan administrator
is your group administrator or the person selected by your employer to administer the continuation of coverage (COBRA) provision.

Post-service claims
are all claims other than pre-service claims and urgent care claims. Post-service claims include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where you request authorization in advance.

Pre-service claims
are claims for a service where the terms of the EOC require the member to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a post-service claim.
**Prescription drug**

is a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

- Compounded (combination) medications, which the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription do dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer

- Insulin, diabetic supplies, and syringes.

**Primary care physician (“PCP”)**

is the HealthKeepers physician you must select to provide primary health care and to coordinate the other covered services you may require. PCPs specialize in the areas of general practice, family practice, internal medicine, and pediatrics.

**Qualified beneficiary**

is the subscriber or a covered dependent who is eligible to continue coverage under COBRA.

**Qualifying event**

is an event that causes you or your enrolled dependents to select continuation of coverage under COBRA. The events are detailed in the **After coverage ends** section.

**Referral**

is authorization from your PCP to receive services from another provider, however your coverage does not require that you obtain a referral from your PCP to receive care from other HealthKeepers providers.

**Retail health clinic**

is a clinic that provides limited basic medical care services to members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physician’s assistants and nurse practitioners.

**Service area**

is the geographic area within which covered services are available.

**Special condition**

is a condition or disease that is life-threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.

**Specialty drugs**

are drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

**Stay**
is the period from the admission to the date of discharge from a facility, including hospitals, hospices and skilled nursing facilities. All facility stays, for the same or related condition, less than 72 hours apart are considered the same stay, and a new inpatient copayment will not apply.

**Subscriber**
is the eligible employee as defined in the agreement who has elected coverage for himself/herself and his/her dependents (if any) who meet the eligibility requirements of this EOC and enrolls in HealthKeepers, and for whom the premium required by the agreement has been paid to HealthKeepers.

**Telemedicine services**
means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine services do not include an audio-only telephone conversations, electronic mail message, or facsimile transmission.

**Urgent care claims**
are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain. Notwithstanding any provision of this EOC, services for a true emergency do not require PCP referrals or any type of HealthKeepers advance approval.

**Urgent care situations**
are medical conditions that require immediate attention, but are not as severe as an emergency. Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury.

**Visit**
is a period during which a member meets with a provider to receive covered services.

**You, your**
any member.
Exhibit A

Experimental/Investigative Criteria
Experimental/investigative means any service or supply that is judged to be experimental or investigative at HealthKeeper’s sole discretion. Nothing in this exclusion shall prevent a member from appealing HealthKeeper’s decision that a service is experimental/investigative. Services which do not meet each of the following criteria will be excluded from coverage as experimental/investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration (“FDA”) for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

   a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
      • the following three standard reference compendia defined below:
        1) American Hospital Formulary Service - Drug Information
        2) National Comprehensive Cancer Network’s Drugs & Biologics Compendium
        3) Elsevier Gold Standard’s Clinical Pharmacology
      • in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
     
   b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.

3. The available scientific evidence must show a good effect on health outcomes outside a research setting.
4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered experimental/investigative.

**Clinical Trial Costs**

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are *covered services* under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a. The National Institutes of Health.
   b. The Centers for Disease Control and Prevention.
   c. The Agency for Health Care Research and Quality.
   d. The Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

*Your* plan may require you to use an in-network provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a *covered service* even though it might otherwise be investigational as defined by this plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our clinical coverage guidelines, related policies and procedures.

*Your* plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

   i. The investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.
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End of Evidence of Coverage
Special features and programs

In addition to the health and wellness benefits under HealthKeepers, our plans are designed to give you services and information to help you maintain and improve your health and reach your health potential.

Your health account

You may be offered the opportunity to establish a health account for your health account dollars. If you have the opportunity and choose to establish a health account, it will work like a bank account to give you control over a portion of the dollars you spend on your health.

When you establish a health account, the dollars in it are funded by your contributions, including pre-tax payroll deductions and post-tax deposits. Your employer may also choose to make contributions to your health account. You can continue to make contributions for as long as you remain enrolled in an HSA-compatible health plan. However, once you leave an HSA-compatible health plan, you can no longer make additional contributions to your health account.

You may use the dollars in your health account to pay for covered services subject to deductible and coinsurance amounts you incur while covered under this health plan. In addition, your health account dollars may be used for any medically qualified services and supplies as defined by the Internal Revenue Service HSA expenditures rules for medical and dental expenses. If health account dollars are used for things other than defined HSA expenditures, there may be tax implications. Please consult your tax advisor for information and advice.

Once established, the health account is totally portable. You control the account, and can build up the balance of dollars in the account over time. Any unused health care dollars can be rolled over year after year. If your coverage under this health plan ends for any reason, any balance of unused account dollars remains under your control, until the account is depleted.

Other tools and services

The following programs, tools and services are also included. Although these services are not part of the health and wellness benefits under your health plan, they are provided to you as a plan participant. Discount services are available through networks administered by other companies - many of which are national leaders in their fields. The discount services listed below are not covered as benefits under your health plan and can be discontinued at any time.

24/7 NurseLine

Illness or injury can happen, no matter what time of day. As a HealthKeepers member you have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and you can call as often as you like. Call 866-800-8780.
AudioHealth Library
For those who aren’t comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, there’s the AudioHealth Library. It’s accessible by phone with more than 400 recorded health topics.

Online Preventive Guidelines
At anthem.com, you can use the online preventive guidelines to check on when you should have certain check-ups, immunizations, screenings and tests.

Healthy Solutions Newsletter
Mailed to your home twice a year, this wellness and benefits newsletter can help you make wiser decisions about your health and the care you need. Packed with practical information, it can help you get the most value out of your health care benefits.

SpecialOffers@Anthem℠
With SpecialOffers@Anthem, you can access discounts on a wide variety of health and wellness products and services. Find deals on natural health and wellness products; acupuncture, chiropractic and massage therapy; fitness club memberships; weight management; laser vision correction and recommended health and wellness books.

The discount programs and services available through SpecialOffers@Anthem are continually reviewed for opportunities to provide more value to your membership. For the most up-to-date information, always refer to SpecialOffers@Anthem at anthem.com. These discount programs and services are independent of your plan benefits and may change or be cancelled at any time.