



Ready to choose your benefits?
We can point you in the right direction.

Montgomery County
Effective October 1, 2016



And Its Affiliate HealthKeepers, Inc.

An Anthem Blue Cross and Blue Shield ID card means something

It means you have access to quality care from quality doctors. It means you can always get your questions answered. It means you have our support before you ever need health care. And that's what this guide is for. We want you to have everything you need to make a good decision.



You can register at [anthem.com](https://www.anthem.com) or on the mobile app — your simple and convenient solution to managing your health.

Frequently asked questions (FAQ)

Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your benefits if you choose a doctor in your plan. Some plans cover only services from doctors in your plan, which means you pay for the full cost if you see a doctor outside of the plan. Other plans cover services from doctors outside the plan — but your plan pays more of the cost when you see a doctor in your plan. Be sure to check the details of your plan.

To find out if your doctor is in the plan, or to find a new doctor in the plan, go to our *Find a Doctor* tool on [anthem.com](https://www.anthem.com). You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the doctors that serve your plan. You can also use *Find a Doctor* on your smartphone.

What prescription drugs are covered?

View the drugs we cover at www.anthem.com/national3tier.

And here's a tip: you'll often pay less for generic versions of higher-cost name brand drugs.

To learn more about helpful RX programs, check out the Customer Support section on [anthem.com](https://www.anthem.com). Then go to FAQ>Pharmacy.

How do I use my health plan when I need care?

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor. You can also show a copy of your ID card from the Anthem mobile app.

Is preventive care covered?

Yes, preventive care from a doctor in the plan is covered at 100%. It's very important to take care of your health with regular checkups even when you feel fine. So talk to your doctor about screenings and immunizations that you may need to protect your health.

Can I manage my plan and health care on [anthem.com](https://www.anthem.com)?

Yes. As soon as you become a member, you'll be able to register at [anthem.com](https://www.anthem.com) or on the Anthem mobile app.

It's designed to help you manage your health care and your benefits simply and conveniently. Many of our members find these self-service tools helpful:

- Check on your claims.
- Find a doctor.
- Check the price of a drug and refill a prescription.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.
- View your health account balance and claims

Visit [anthem.com/guidedtour](https://www.anthem.com/guidedtour) to watch a video explaining how our website can help you.

Do I have health and wellness benefits with my plan?

Yes. In fact, we have a set of tools and resources that can help you reach your health goals. They can also save you money on products and services for your health. Just go to [anthem.com](https://www.anthem.com) and click the *Health & Wellness* tab. Once you're a member, you can log in and see more.

Check out these health and wellness programs your employer is providing in addition to your health benefits:

24/7 NurseLine — Our registered nurses can answer your health questions wherever you are — any time, day or night.

Future Moms — Moms-to-be get personalized support and guidance from registered nurses to help them have a healthy pregnancy, a safe delivery and a healthy baby.

ConditionCare — Get the added support you may need if you have asthma, diabetes, heart disease, chronic obstructive pulmonary disease or heart failure. A nurse coach can answer questions about your health and help you reach your health goals based on your doctor's care plan. You can work with dietitians, health educators, pharmacists and social workers to reach those goals and feel your best.

Healthy Lifestyles — Take charge of your total wellness through a personalized Well-Being Plan and custom trackers that help you manage your physical and mental health.



Frequently asked questions (FAQ)

MyHealth Advantage — Avoid health problems, stay healthy and save money. This program tracks your health information to see if there's anything you can do to improve your health. If so, you'll get a personalized and confidential MyHealth Note in the mail.

How can Anthem help me save money?

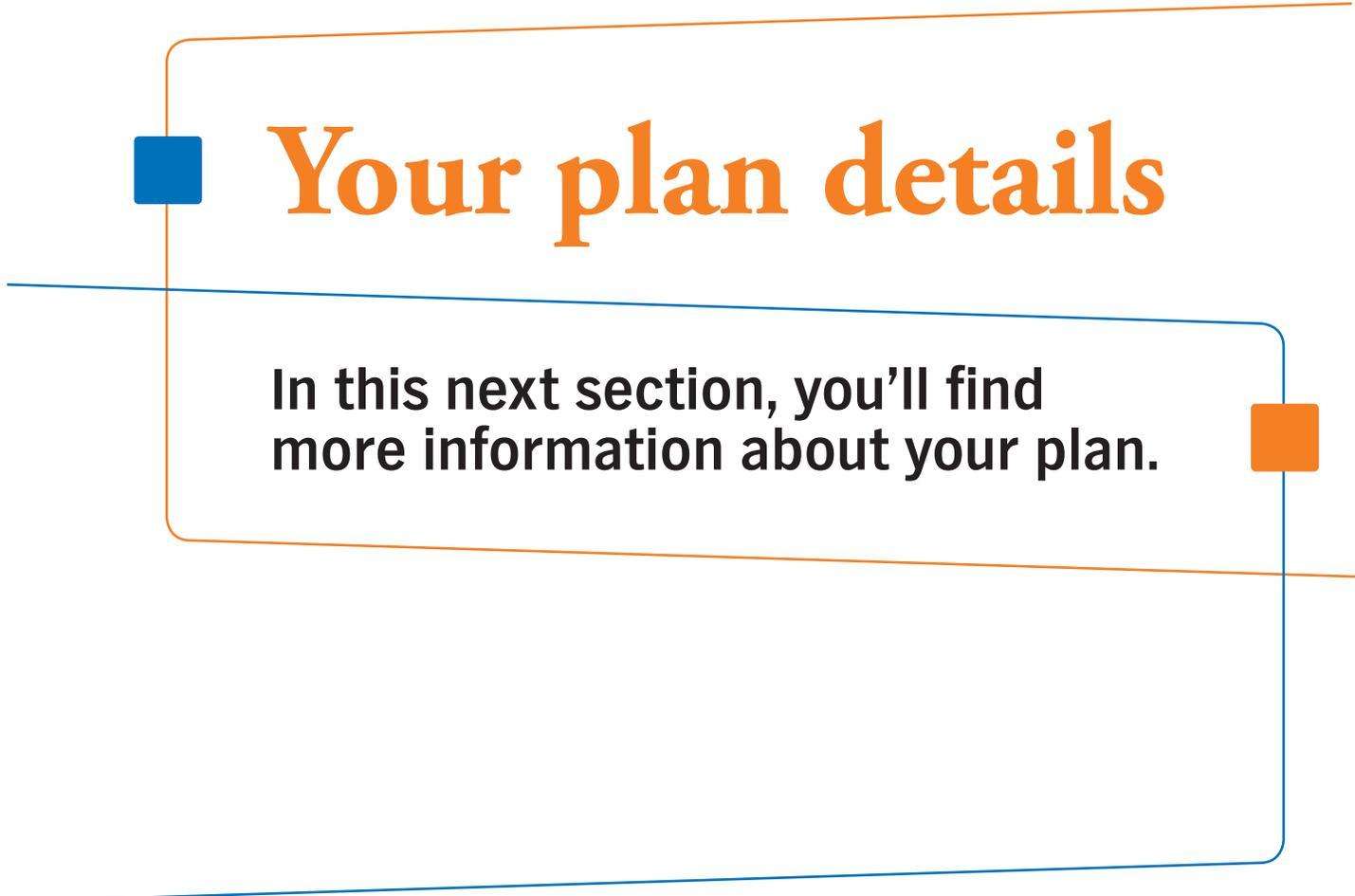
You'll save money every time you go to a doctor in your plan — they've agreed to charge lower rates for Anthem members. But we'll also help save you money before you go to the doctor.

At anthem.com, you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products. You can even print your own coupons for healthier groceries. Check out these cost saving programs your employer is also offering.

Health Savings Account (HSA) - An HSA allows you to set aside money from your income, before taxes, to use on qualified health care expenses. During Open Enrollment, you decide how much you would like your employer to deduct from your paychecks to put in your HSA. You'll get a debit card in the mail to help pay for your doctors visits or prescriptions with the money you have in your HSA.

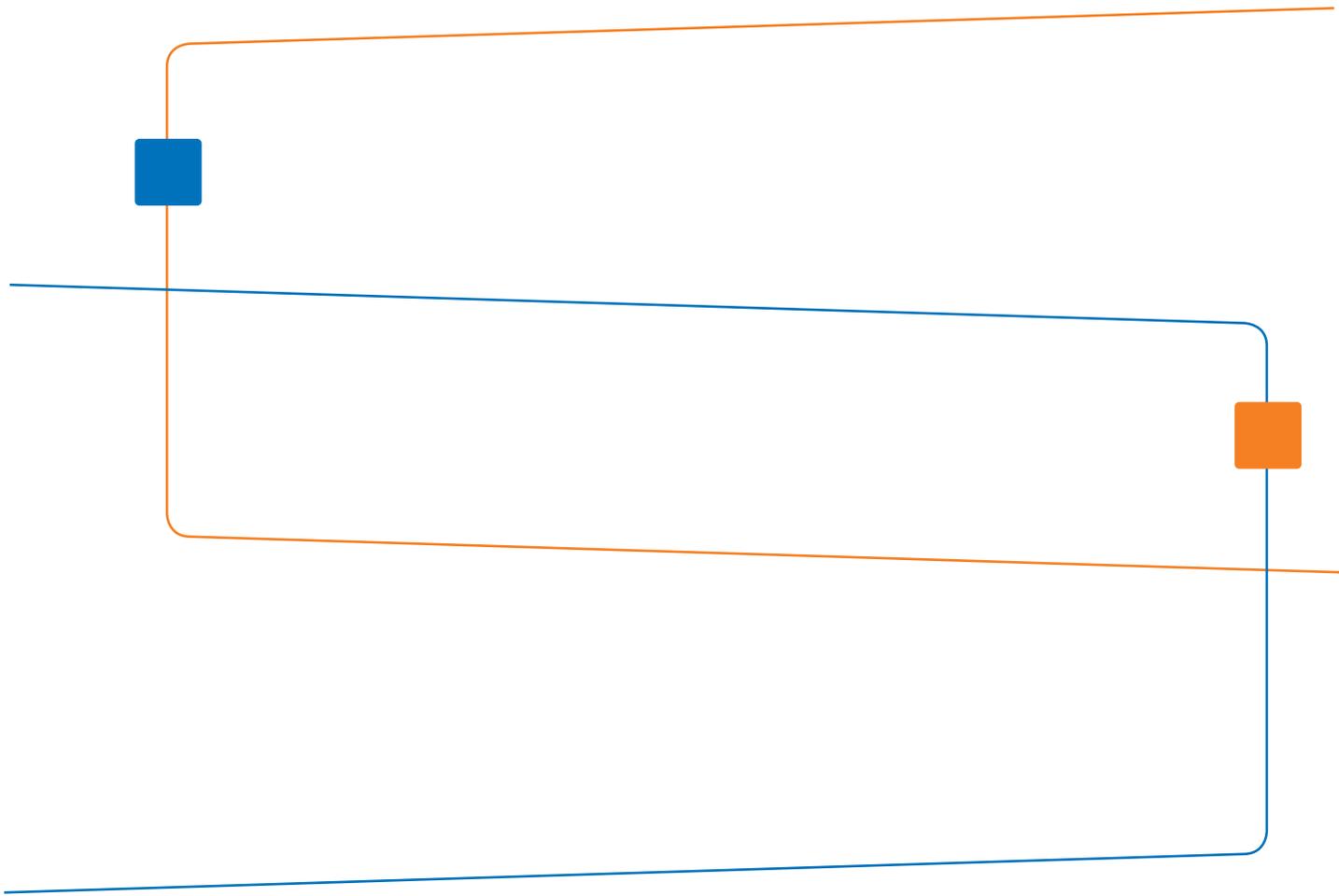
The money isn't taxed - so you get to keep more of your income. You can add up to \$3,350 for individuals and \$6,750 for families.

LiveHealth Online — Using LiveHealth Online, you can have a video visit with a board-certified doctor or therapist on your smartphone, tablet or computer with a webcam. It's easy to use and there when you need it. All you have to do is sign up to use it at livehealthonline.com or download the app.



Your plan details

In this next section, you'll find more information about your plan. 



Anthem KeyCare 200 Plan

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	No charge*
Doctor Visits	
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ pre- and postnatal office visits ○ home visits 	\$20 for each visit to a PCP \$40 for each visit to a specialist
○ in-office surgery	20% of the amount the health care professionals in our network have agreed to accept for their services
○ mental health and substance use visits	No charge
Labs and Diagnostic X-rays	
<ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays 	20% of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Facility Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit* <i>*Inpatient Professional benefits for this setting are listed on the next page.</i>	\$300 plus 20% of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Facility Surgical Care and Emergency Room Services	
<ul style="list-style-type: none"> ○ emergency room* ○ surgery* <i>*Professional benefits for this treatment are listed on the next page.</i>	\$100 plus 20% of the amount the health care professionals in our network have agreed to accept for their services
Routine Vision	
<ul style="list-style-type: none"> ○ annual routine eye exam <i>Plus valuable discounts on eyewear</i> 	\$15 for each visit

All Other In-Network Services	You Pay
<p>You will pay all the costs associated with your care until you have paid \$200 in one calendar or plan year. This is known as your deductible.</p> <ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay the first \$200 of the cost of your care (\$400 total). ○ If three or more people are covered under your plan, together you will pay the first \$400 of the cost of your care. However, the most one family member will pay is \$200. <p>Your benefit period will be a calendar year. A calendar year means your benefit period runs from January through December. Any amount you pay toward your deductible during the 4th quarter of each calendar year- October, November, December- will apply not only to your deductible for that year but will also apply to your deductible for the following year.</p> <p>Once you reach your deductible you pay:</p>	
Outpatient Services	

In most of Virginia: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. (serving Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123). Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

<ul style="list-style-type: none"> ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy ○ spinal manipulations and other manual medical intervention visits (30 visit limit) ○ dialysis ○ ambulance travel ○ durable medical equipment 	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
<ul style="list-style-type: none"> ○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> ○ behavioral health treatment* ○ psychiatric care ○ therapeutic care** ○ pharmacy care ○ psychological care <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ applied behavioral analysis <ul style="list-style-type: none"> ○ unlimited per member annual maximum 	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
<ul style="list-style-type: none"> ○ unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* ○ physician services ○ mental health and substance use partial-day treatment programs <p>*Limit does not apply to Autism Spectrum Disorder.</p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ emergency room professional services ○ surgical professional services 	20% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> ○ home health care (100 visits) ○ private duty nursing limited to 16 hours per member per calendar year <p>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.</p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ hospice care 	No charge
Inpatient Professional Care	
<ul style="list-style-type: none"> ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services ○ skilled nursing facility care (100 days for each admission) 	20% of the amount the health care professionals in our network have agreed to accept for their services

For benefits listed with specific limits all services received in the calendar year or plan year for that benefit are applied to that limit (whether received in or out of network).

Out-of-Network Services

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

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$300 in one calendar or plan year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first \$300 of the cost of your care (\$600 total).
- If three or more people are covered under your plan, together you will pay the first \$600 of the cost of your care. However, the most one family member will pay is \$300.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$300 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar or Plan Year

When using network professionals

If you are the only one covered by your plan, you will pay \$3,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

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

When not using network professionals

If you are the only one covered by your plan, you will pay \$4,750 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay \$4,750 (\$9,500 total).
- If three or more people are covered under your plan, together you will pay \$9,500. However, no family member will pay more than \$4,750 toward the limit.

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

- your share of the cost of routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 200 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

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

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

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Your prescription drug plan- KeyCare 200 Plan

Your Prescription Drug 10-30-50 Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	\$10	\$30	\$50
Up to a 90-day medication supply delivered to your home	\$10	\$60	\$150

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum. Please refer to the benefit summary included with your enrollment brochure for the out-of-pocket maximum established for your medical and pharmacy benefit.

Retail pharmacy network

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

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

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

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

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

Note about your pharmacy information on the web:

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

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

Home Delivery Pharmacy

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

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

Your prescription drug plan (continued)

Getting started with home delivery

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

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

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

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

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

Ordering refills

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

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

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

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

Online: Visit anthem.com.

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

Specialty Pharmacy

Accredo, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. They include (but are not limited to):

- Asthma
- Bleeding Disorders

Your prescription drug plan (continued)

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

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

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

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

Ordering specialty drugs

You can place your first order by phone or fax

By phone: Call **Accredo member services at 800-803-2523**, Monday through Friday, 8 a.m. to 11 p.m. and Saturday 8 a.m. to 5 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your ID card to Accredo at **800-391-9707**, or your doctor can call in your prescription by phone by calling Accredo at **866-759-1557**.

Ordering refills

Online: Visit **anthem.com**.

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

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

Drug list

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

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

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

Your prescription drug plan (continued)

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

Generic drugs

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

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

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

Why generics cost less

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

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

Prior authorization

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

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

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

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

Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

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

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Anthem KeyCare 1,000

In-Network Services	You Pay	
Preventive Care Services		
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	No charge*	
Routine Vision		
<ul style="list-style-type: none"> ○ annual routine eye exam <i>Plus – valuable discounts on eyewear</i> 	\$15 for each visit	
All Other In-Network Services		
<p>You will pay all the costs associated with your care until you have paid \$1,000 in one calendar or plan year. This is known as your deductible.</p> <ul style="list-style-type: none"> ○ If two people are covered under your plan, each of you will pay the first \$1,000 of the cost of your care (\$2,000 total). ○ If three or more people are covered under your plan, together you will pay the first \$2,000 of the cost of your care. However, the most one family member will pay is \$1,000. <p>Your benefit period will be a calendar year. A calendar year means your benefit period runs from January through December. Any amount you pay toward your deductible during the 4th quarter of each calendar year- October, November, December- will apply not only to your deductible for that year but will also apply to your deductible for the following year.</p> <p>Once you reach your deductible you pay:</p>		
Doctor Visits		
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits ○ mental health and substance use visits ○ in-office surgery * Limit does not apply to Autism Spectrum Disorder. 	<ul style="list-style-type: none"> ○ physical and occupational therapy in an office setting (30 combined visits)* ○ speech therapy visits in an office setting (30 visit limit)* ○ spinal manipulations and other manual medical intervention visits (30 visit limit) 	20% of the amount the health care professionals in our network have agreed to accept for their services
Labs and Diagnostic X-rays		
<ul style="list-style-type: none"> ○ diagnostic lab services ○ diagnostic x-rays 	20% of the amount the health care professionals in our network have agreed to accept for their services	
Outpatient Services		
<ul style="list-style-type: none"> ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy 	<ul style="list-style-type: none"> ○ dialysis ○ ambulance travel ○ durable medical equipment 	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 	Member cost shares will be dependent on the services rendered.	
Autism Spectrum Disorder (ASD) – For children from age 2 through 10		
<ul style="list-style-type: none"> ○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> ○ behavioral health treatment* ○ psychiatric care ○ therapeutic care** 	<ul style="list-style-type: none"> ○ pharmacy care ○ psychological care 	Member cost shares will be dependent on the services rendered.
<p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>		
<ul style="list-style-type: none"> ○ applied behavioral analysis <ul style="list-style-type: none"> ○ unlimited per member annual maximum 	20% of the amount the health care professionals in our network have agreed to accept for their services	

In-Network Services	You Pay
Early Intervention – For children from birth up to 3	
<ul style="list-style-type: none"> ○ unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* ○ mental health and substance use partial-day treatment programs * Limit does not apply to Autism Spectrum Disorder. 	<ul style="list-style-type: none"> ○ surgery ○ emergency room ○ physician services 20% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> ○ home health care (100 visits) ○ private duty nursing is limited to 16 hours per member per calendar year* * Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged. 	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ hospice care 	No charge
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services ○ skilled nursing facility care (100 days for each admission) 	20% of the amount the health care professionals in our network have agreed to accept for their services

For benefits listed with specific limits all services received in the calendar year or plan year for that benefit are applied to that limit (whether received in or out of network).

Out-of-Network Services

Using doctors, hospitals and other health care professionals not contracted to provide benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid \$1,500 in one calendar or plan year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first \$1,500 of the cost of your care (\$3,000 total).
- If three or more people are covered under your plan, together you will pay the first \$3,000 of the cost of your care. However, the most one family member will pay is \$1,500.

Once you have reached this amount, when you receive covered services we will pay 60% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached the \$1,500 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar or Plan Year

When using network professionals

If you are the only one covered by your plan, you will pay \$5,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay \$5,000 (\$10,000 total).
- If three or more people are covered under your plan, together you will pay \$10,000. However, no family member will pay more than \$5,000 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay \$6,250 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.*

- If two people are covered under your plan, each of you will pay \$6,250 (\$12,500 total).
- If three or more people are covered under your plan, together you will pay \$12,500. However, no family member will pay more than \$6,250 toward the limit.

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

- your share of the cost of routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 1,000 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

This benefits overview insert is only one piece of your entire enrollment package.

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

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Your prescription drug plan- KeyCare 1000 Plan

Your Prescription Drug 15-30-60 Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	\$15	\$30	\$60
Up to a 90-day medication supply delivered to your home	\$15	\$60	\$180

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum. Please refer to the benefit summary included with your enrollment brochure for the out-of-pocket maximum established for your medical and pharmacy benefit.

Retail pharmacy network

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

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

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

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

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

Note about your pharmacy information on the web:

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

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

Home Delivery Pharmacy

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

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

Your prescription drug plan (continued)

Getting started with home delivery

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

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

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

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

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

Ordering refills

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

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

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

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

Online: Visit anthem.com.

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

Specialty Pharmacy

Accredo, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. They include (but are not limited to):

- Asthma
- Bleeding Disorders
- Cancer
- Cystic Fibrosis
- Crohn’s Disease
- Growth Hormone
- Hepatitis
- HIV/AIDS
- Iron Overload
- Multiple sclerosis

Your prescription drug plan (continued)

- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

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

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

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

Ordering specialty drugs

You can place your first order by phone or fax

By phone: Call **Accredo member services at 800-803-2523**, Monday through Friday, 8 a.m. to 11 p.m. and Saturday 8 a.m. to 5 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your ID card to Accredo at **800-391-9707**, or your doctor can call in your prescription by phone by calling Accredo at **866-759-1557**.

Ordering refills

Online: Visit **anthem.com**.

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

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

Drug list

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

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

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

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

Generic drugs

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

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

Your prescription drug plan (continued)

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

Why generics cost less

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

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

Prior authorization

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

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

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

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

Anthem Blue Cross and its affiliate, HealthKeepers, Inc., receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem Blue Cross and Blue Shield and Anthem HealthKeepers members. These credits are retained by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

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Lumenos HSA

In-Network Services	You Pay	
Preventive Care Services		
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and <i>your</i> provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by <i>your</i> provider, which will result in a member cost share.	No charge*	
Routine Vision		
<ul style="list-style-type: none"> ○ annual routine eye exam <li style="padding-left: 20px;"><i>Plus – valuable discounts on eyewear</i> <p>If you go to an eye care professional not in our network for your routine eye examination, we will pay \$30 (whether or not you have reached your deductible) and you will pay the rest of what the provider charges.</p>	\$15 for each visit	
Annual Deductible		
<p>Your deductible is combined for In-network and Out-of-Network services.</p> <ul style="list-style-type: none"> ○ For single coverage, you will pay all the costs associated with your care until you have paid \$1,300 in one calendar or plan year. ○ If two or more people are covered under your plan, together you will pay the first \$2,600 of the cost of care in one calendar or plan year. <p>In-Network Services Once you and your covered family members have reached your deductible, you will pay the amounts designed below in the “you pay” column.</p> <p>Out-of-Network Services For covered services to out-of-network providers, you will pay 40%. However, it’s important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts.</p>		
Once you reach your deductible, you will pay the following for covered in-network services		
All Other In-Network Services		
Doctor Visits		
<ul style="list-style-type: none"> ○ office visits ○ urgent care visits ○ home visits ○ pre- and postnatal office visits ○ mental health and substance use visits ○ in-office surgery <p>* Limit does not apply to Autism Spectrum Disorder.</p>	<ul style="list-style-type: none"> ○ physical and occupational therapy in an office setting (30 combined visits)* ○ speech therapy visits in an office setting (30 visit limit)* ○ spinal manipulations and other manual medical intervention visits (30 visit limit) 	20% of the amount the health care professionals in our network have agreed to accept for their services
Labs, Diagnostic X-rays and Other Outpatient Services		
<ul style="list-style-type: none"> ○ diagnostic lab services ○ shots and therapeutic injections ○ medical appliances, supplies and medications, including infusion medications ○ chemotherapy (not given orally), radiation, cardiac and respiratory therapy 	<ul style="list-style-type: none"> ○ diagnostic x-rays ○ dialysis ○ ambulance travel ○ durable medical equipment 	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ diabetic supplies, equipment and education 		Member cost shares will be dependent on the services rendered.

Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
<ul style="list-style-type: none"> ○ diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> ○ behavioral health treatment* ○ psychiatric care ○ therapeutic care** ○ pharmacy care ○ psychological care <p>* Mental Health Services **Unlimited physical, occupational and speech therapy.</p>	Member cost shares will be dependent on the services rendered.
<ul style="list-style-type: none"> ○ applied behavioral analysis <ul style="list-style-type: none"> ○ unlimited per member annual maximum 	20% of the amount the health care professionals in our network have agreed to accept for their services
Early Intervention – For children from birth up to age 3	
<ul style="list-style-type: none"> ○ unlimited per member per calendar year up to age 3 	Member cost shares will be dependent on the services rendered.
Outpatient Visits in a Hospital or Facility	
<ul style="list-style-type: none"> ○ physical therapy and occupational therapy (30 combined visits)* ○ speech therapy (30 visit limit)* ○ surgery ○ emergency room ○ physician services ○ mental health and substance use partial-day treatment programs <p>* Limit does not apply to Autism Spectrum Disorder.</p>	20% of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
<ul style="list-style-type: none"> ○ home health care (100 visits) ○ private duty nursing is limited to 16 hours per member per calendar year* <p>*Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.</p>	20% of the amount the health care professionals in our network have agreed to accept for their services
<ul style="list-style-type: none"> ○ hospice care 	20% of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
<ul style="list-style-type: none"> ○ semi-private room, intensive care or similar unit ○ physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services ○ skilled nursing facility care (100 days for each admission) 	20% of the amount the health care professionals in our network have agreed to accept for their services
Retail or Specialty Pharmacy	
<ul style="list-style-type: none"> ○ Up to a 30-day medication supply at participating pharmacies <i>Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.</i> 	20% of the amount the health care professionals in our network have agreed to accept for their services
Home Delivery or Specialty Pharmacy	
<ul style="list-style-type: none"> ○ Up to a 90-day medication supply delivered to your home <i>Most specialty medications are limited to up a 30 day supply regardless of whether they are retail or mail.</i> 	20% of the amount the health care professionals in our network have agreed to accept for their services

Your benefit period runs on a calendar year. A calendar year means your benefit period runs from January 1 through December 31.

For benefits listed with specific limits all services received in the calendar year or plan year for that benefit are applied to that limit (whether received in or out of network).

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Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar or Plan Year

When using network professionals

For single coverage, you will pay \$3,425 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan; together you will pay \$6,850. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

When not using network professionals

For single coverage, you will pay \$5,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan; together you will pay \$10,000. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

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

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

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

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The ins and outs of coverage

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

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

- Who can be enrolled.
- How coverage changes are handled.
- What's not covered by your plan.
- How your plan works with other coverage.

Who can be enrolled

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

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

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

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

1. On the employer level – which impacts you, as well as all employees under your employer's plan – your plan can be . . .

renewed	canceled	changed	when . . .
•			Your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	•		Your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	•		We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		•	Your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Lumenos coverage.

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

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



The ins and outs of coverage

(continued)

Special enrollment periods

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

However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

When you're covered by multiple plans

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

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



The ins and outs of coverage

(continued)

Determining the primary versus secondary carrier

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

When a person is covered by two group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	●	
	The plan with COB is		●
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	●	
	The plan covering the person as a dependent is		●
The person is the participant in two active group plans	The plan that has been in effect longer is	●	
	The plan that has been in effect the shorter amount of time is		●
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	●	
	The COBRA plan is		●
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent’s plan is	●	
	The noncustodial parent’s plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	



The ins and outs of coverage

(continued)

How benefits apply when Medicare-eligible

Some people under age 65 are eligible for Medicare in addition to any other coverage they may have. The following chart shows how payment is coordinated under various scenarios:

When a person is covered by Medicare and a group plan, and	Then	Your plan	Medicare is primary
Is a person who is qualified for Medicare coverage due solely to end-stage renal disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	●	
	Upon completion of the 30-month Medicare entitlement period		●
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	●	
	If the group plan has fewer than 100 participants		●
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	●	
	If Medicare had been primary to the group plan before ESRD entitlement		●

Recovery of overpayments

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

- Any person to or for whom the overpayments were made.
- Any health care company.
- Any other organization.



The following services and supplies will not be covered under your plan.

The ins and outs of coverage

(continued)

What's not covered (exclusions)

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

Acupuncture

Biofeedback therapy

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

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

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

- 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 us for prior approval. No approval of a plan of treatment by us is required for emergency treatment of a dental injury.
 - Biting and chewing 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.
 - Anesthesia and hospitalization for dental procedures and services except as specified as otherwise being covered.
 - Oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures.
 - Periodontal care, prosthodontal care or orthodontic care.
- 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.



The ins and outs of coverage

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

Educational, vocational or self management training purposes, except as otherwise specified as being covered or when received as part of covered preventive care.

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

Family planning

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

Services for palliative or cosmetic **foot** care

- Flat foot conditions
- Support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- Foot orthotics
- Subluxations of the foot
- Corns, calluses and care of toenails (except in treatment for patients with diabetes or vascular disease)
- Bunions (except capsular or bone surgery)
- Fallen arches, weak feet, chronic foot strain
- Symptomatic complaints of the feet

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

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

Hearing aids or for examinations to prescribe or fit hearing aids, except for cochlear implants, are not covered.

Home care services

- Homemaker services (except as rendered as part of Hospice care)
- Maintenance therapy
- Food and home-delivered meals
- Custodial care and services

Hospital services

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



The ins and outs of coverage

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

Medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use:

- Exercise equipment
- Air conditioners, dehumidifiers, humidifiers, and purifiers
- Hypoallergenic bed linens
- Whirlpool® baths
- Handrails, ramps, elevators, and stair glides
- Telephones
- Adjustments made to a vehicle
- Foot orthotics
- Changes made to a home or place of business
- Repair or replacement of equipment you lose or damage through neglect

Medical equipment (durable) that is not appropriate for use in the home.

Services or supplies deemed not **medically necessary** as determined by us at our sole discretion. Notwithstanding this exclusion, all preventive care services and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by us to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or

anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal our decision that a service is not medically necessary.



Experimental ... or not?

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

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



The ins and outs of coverage

(continued)

Mental health and substance use

- Inpatient stays for environmental changes
- Cognitive rehabilitation therapy
- Educational therapy
- Vocational and recreational activities
- Coma stimulation therapy
- Services for sexual deviation and dysfunction
- Treatment of social maladjustment without signs of a psychiatric disorder
- Remedial or special education services

Nutrition counseling and related services, except when provided as part of diabetes education, mental health treatment of an eating disorder or when received as part of a covered preventive care services visit or screening.

Nutritional and/or dietary supplements, except as specifically listed in this enrollment brochure or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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

Organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical

teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high-dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

Paternity testing

Prescription drug benefits

- Administrative charges: Charges for the administration of any drug except for covered immunizations as approved by us or the Pharmacy Benefits Manager.
- Compound drugs: Compound drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA-approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- 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 the doctor. This exclusion does not apply to drugs used with diagnostic services, drugs used during chemotherapy in the office, or drugs covered under the medical supplied benefit; those would be 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 us at anthem.com. If you or your doctor believes you need a certain prescription drug not on the list, please refer to the "prescription drug benefits at a retail or home delivery (mail order) pharmacy" section in your post enrollment *Evidence of Coverage* for details on requesting an exception.



The ins and outs of coverage

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- 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 the 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 a refill given more than one year after the date of the original prescription order.
- Infertility treatments: 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.
- Items covered 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.
- Mail-order providers other than our home delivery mail-order provider: Prescription drugs dispensed by any mail order provider other than our mail order provider unless we must cover them by law.
- Non-approved drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless we must cover the use by law or if we, or the Pharmacy Benefits Manager, approve it.
- Onychomycosis drugs: Drugs for Onychomycosis (tonail fungus), except when we allow it to treat members who are immuno-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 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 mainly used for weight loss. This exclusion does not apply to over-the-counter products that we must cover as a preventive care benefit under federal law with a prescription.

Your coverage does not include benefits for **private duty nurses** in an inpatient setting.

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



The ins and outs of coverage

(continued)

Services or supplies or devices:

- Not listed as covered under your health plan
- Not prescribed, performed, or directed by a provider licensed to do so.
- Received before the effective date or after a covered person's coverage ends.
- Services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- Benefits for charges from stand-by physicians in the absence of covered services being rendered.
- Telephone consultations, charges for not keeping appointments, or charges for completing claim forms.

Services or supplies if provided or available to a member:

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

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

- Amounts above the allowable charge for a service
- Neurofeedback, and related diagnostic tests
- Penile implants

Services or supplies if they are received from providers not licensed by law to provide services. Examples include masseurs (massage therapists), physical therapist technicians and athletic trainers.

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

Skilled nursing facility stays

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

Smoking cessation programs not affiliated with us

Your coverage does not include benefits for **spinal manipulation** other manual medical interventions for an illness or injury other than musculoskeletal conditions.

Telemedicine

Non-interactive telemedicine services, including audio-only telephone, electronic mail message, facsimile transmissions or online questionnaire.

Therapies

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

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

Vision services

- For members through age 18, there is no benefit for frames or contact lenses purchased outside of our formulary.



The ins and outs of coverage

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- Vision services or supplies, unless needed due to eye surgery and accidental injury
- Routine vision care and materials
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure
- Services for vision training and orthoptics
- Tests associated with the fitting of contact lenses, unless the contact lenses are needed due to eye surgery or to treat accidental injury
- Sunglasses or safety glasses and accompanying frames of any type
- Any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- Any lost or broken lenses or frames
- Cosmetic lens options that are not otherwise specifically listed as covered.
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- Any other vision services not specifically listed as covered

Waived cost shares

Your coverage does not include waived cost shares out-of-plan. For any service in which you are responsible under the terms of this plan to pay a copayment, coinsurance or deductible, and the copayment coinsurance or deductible is waived by an out-of-network provider.

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

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



Let's talk about your privacy and rights

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And you also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

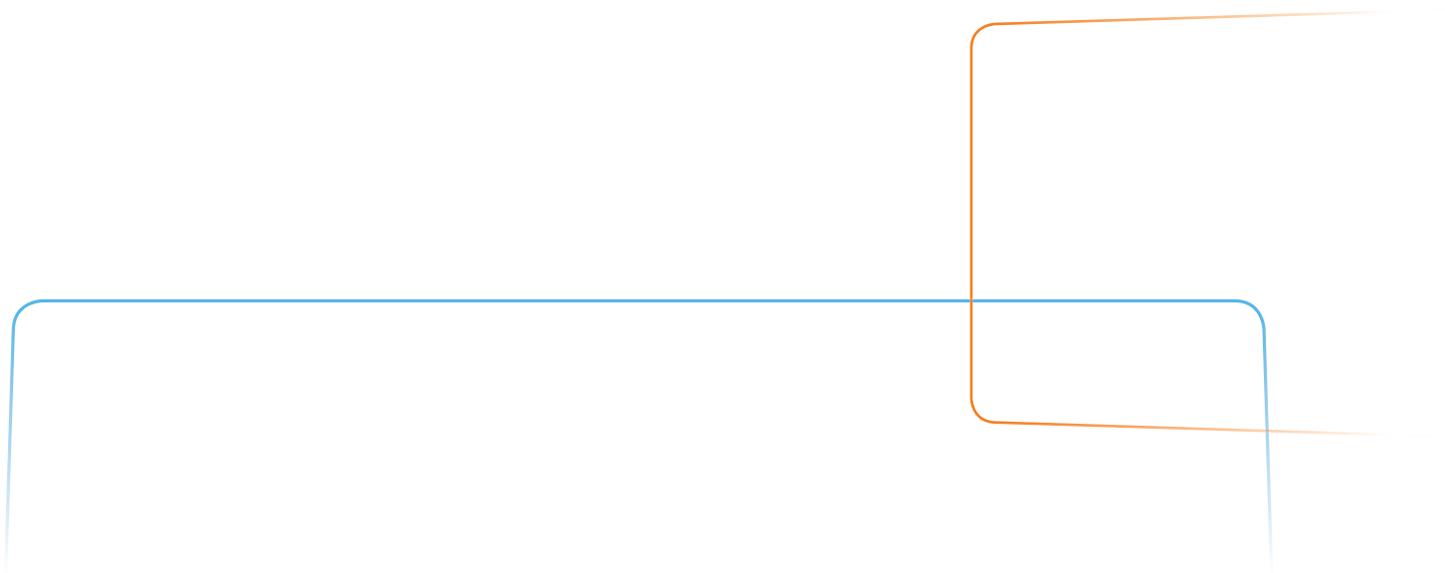
How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you

learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more about how we help manage your care, visit www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.



You've got health goals
We've got your back.



And Its Affiliate HealthKeepers, Inc.

These policies have exclusions and limitations to benefits and terms under which the policy may be renewed or discontinued. For costs and complete details of the coverage, contact your Benefits Administrator or Anthem.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for KeyCare or Lumenos plans. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: PP-INTRO (1/16), P-TOC (1/14), P-SB6 (1/16), P-SB7 (1/16), P-WORKS (1/16), P-COVERED (1/16), P-EXCL (1/16), P-CLAIMS (1/16), P-COB (1/16), P-ENR (1/15), P-ENDS (1/15), P-INFO (1/16), P-RIGHTS (1/16), P-DEF (1/16), P-EXH-A (1/16), P-INDEX (1/14) Enrollment application used for these plans: 490773 (1/15). This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401. Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.