Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Benefits You Can Count On

Montgomery County
Effective October 1, 2015 - September 30, 2016

Choosing the right plan is a very personal thing.

Use this book to find one that's

- Right for your lifestyle
- Right for your needs
- Right for your peace of mind

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Your guide to benefits

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

Explore the advantages of being an Anthem member.

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

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

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

- Go to anthem.com
- Click on Register
- Create your user name and password

Then you're ready to go!

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Your guide to benefits (continued)

We're on Facebook, Twitter and YouTube.

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

- Facebook.com/HealthJoinIn
- Twitter.com/HealthJoinIn
- YouTube.com/HealthJoinIn

Scan the code with your mobile capable device for a direct link to anthem.com. Don't have a QR code reader? Download the free ScanLife app to your mobile device or visit scanlife.com.

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Understanding your options for health care plans

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

Ask these questions before signing up:

Does the plan:

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

Know the basics of how the plans work

- **Preferred Provider Organization (PPO):** A PPO plan gives you coverage for doctors and hospitals that are in-network and out-of-network. But you save money by choosing in-network health care providers. To learn more, visit anthem.com/PPObasics.
- **Health Savings Account (HSA):** You put money (before it's taxed) into an account and use it for medical expenses. To learn more, check out anthem.com/HSAbasics.

Here are some definitions:

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

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

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

Know your costs

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

Understanding your options for health care plans (continued)

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

Think about the following:

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

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

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Helpful links

anthem.com

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

Facebook.com/HealthJoinIn

While you're there check out the Health Personality Quiz

Twitter.com/HealthJoinIn

YouTube.com/HealthJoinIn

Healthy Footprint

Glossary

Member Online Tools

Your Health Benefits

Anthem KeyCare PPO Plan

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

> With no primary doctor requirement and no referrals, you're free to make your own decisions about your health care.

One, you have options. Anthem KeyCare is a PPO plan, which means you're free to choose your doctor without referrals. Of course, in-network care will usually cost less than out-of-network care. For many of our KeyCare plans, you'll also pay less when visiting a PCP instead of a specialist. The network includes most doctors and hospitals across the nation, so you'll find plenty of choices. The point is, the choice is yours.

Two, as an Anthem member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health and your budget.

Anthem KeyCare PPO at a glance

- *Primary care physicians (PCPs):* Not required
  You can make your own decisions about your doctors, your care and your costs.
- *Referrals:* Not needed You pick who you want to see. Makes getting second opinions very easy.
- *Claim forms:* No claim forms to submit when using network providers.
- *Out-of-network benefits:* Available, but at lower coverage levels than in-network.
  We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- *Out-of-pocket:* This is the amount you'll pay, whether it is a straight copayment or some percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

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

Anthem KeyCare PPO Plan (continued)

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency, urgent or approved follow-up care, you have three options. Go to anthem.com, call BlueCard® PPO Access at 800-810-2583 or call the customer service number on your member ID card.

You're getting more than a health plan

You get programs to actually help you manage your health. Wellness tools, 360° Health® health management programs, and SpecialOffers@Anthem are all available through anthem.com. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your benefits summary contains the details. Thank you for considering Anthem Blue Cross and Blue Shield.

How to find a network doctor

Anthem networks are some of the largest in the U.S. Simply go online and search our provider directory for the type of care you need.

1. Go to anthem.com.
2. Select "Find a Doctor."
3. Enter your city and state or ZIP and click on "Search."
4. To see only a list of network providers, scroll down to "Insurance Options" and select "Add/Edit Selections."
5. Enter your state, select PPO plan, then "Anthem KeyCare" and click on "Search."

Anthem

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 *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	**No charge***
Doctor Visits	
o office visits o urgent care visits o pre- and postnatal office visits o home visits	**$20** for each visit to a PCP **$40** for each visit to a specialist
o in-office surgery	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o mental health and substance use visits	**No charge**
Labs and Diagnostic X-rays	
o diagnostic lab services o 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	
o semi-private room, intensive care or similar unit* ***Inpatient Professional benefits for this setting are listed on the next page.***	**$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	
o emergency room* o surgery* ***Professional benefits for this treatment are listed on the next page.***	**$100 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services
Routine Vision	
o annual routine eye exam ***Plus valuable discounts on eyewear***	**$15** for each visit

All Other In-Network Services	You Pay
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. o If two people are covered under your plan, each of you will pay the first $200 of the cost of your care ($400 total). o 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. 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. **Once you reach your deductible you pay:**	
Outpatient Services	

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o shots and therapeutic injections o medical appliances, supplies and medications, including infusion medications o dialysis o ambulance travel o durable medical equipment o chemotherapy (not given orally), radiation, cardiac and respiratory therapy o 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
o 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 6	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care * ***Mental Health Services*** ****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o 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	
o 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	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* o physician services o mental health and substance use partial-day treatment programs ****Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o emergency room professional services o surgical professional services	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care (100 visits) o private duty nursing 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
o hospice care	**No charge**
Inpatient Professional Care	
o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services o 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.* o If two people are covered under your plan, each of you will pay $3,500 ($7,000 total). o 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.* o If two people are covered under your plan, each of you will pay $4,750 ($9,500 total). o 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:** o your share of the cost of routine vision care o the cost of care received when the benefit limits have been reached o the cost of services and supplies not covered under your Anthem KeyCare 200 plan o 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. Selet 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

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 *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	**No charge***
Routine Vision	
o annual routine eye exam ***Plus – valuable discounts on eyewear***	**$15** for each visit

All Other In-Network Services	You Pay
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. o 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). o 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. 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. **Once you reach your deductible you pay:**	
Doctor Visits	
o office visits o urgent care visits o home visits o pre- and postnatal office visits o mental health and substance use visits o in-office surgery o physical and occupational therapy in an office setting (30 combined visits)* o speech therapy visits in an office setting (30 visit limit)* o spinal manipulations and other manual medical intervention visits (30 visit limit) **** Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Labs and Diagnostic X-rays	
o diagnostic lab services o diagnostic x-rays	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Outpatient Services	
o shots and therapeutic injections o medical appliances, supplies and medications, including infusion medications o chemotherapy (not given orally), radiation, cardiac and respiratory therapy o dialysis o ambulance travel o durable medical equipment	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o 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 6	
o diagnosis and treatment of autism spectrum disorder including: o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care **** Mental Health Services*** *****Unlimited physical, occupational and speech therapy.***	Member cost shares will be dependent on the services rendered.
o applied behavioral analysis o unlimited per member annual maximum	**20%** of the amount the health care professionals in our network have agreed to accept for their services

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In-Network Services	You Pay
Early Intervention – For children from birth up to 3	
o 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	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* o mental health and substance use partial-day treatment programs o surgery o emergency room o physician services **** Limit does not apply to Autism Spectrum Disorder.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Care at Home	
o home health care (100 visits) o 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
o hospice care	**No charge**
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services o 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.

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. bcr07.15.2015

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

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. Selet 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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How your Lumenos® with Health Savings Account (HSA) plan works

Your Lumenos plan helps you take greater control over the money you spend on health care, while helping you get and stay as healthy as possible. Think of it as a health plan and savings account rolled into one. It starts with a savings account that you put tax-deductible money into. This means you don't have to pay income tax on that money. Then, when you need medical care or a prescription, you can take money out of the account to pay for it.

Your Lumenos also comes with many programs and tools that help you take charge of your health, make smart decisions and save money.

Preventive care is covered 100%

Your plan covers 100% of preventive care when you see a network doctor, so there's nothing taken from your HSA and you won't have to pay out of pocket. To find out more about exams, tests and immunizations you should get, check out the Preventive Care Guidelines at anthem.com.

The plan works like this:

You put tax-free money into your HSA account. You can use that money to help pay deductibles and other health care costs. Your deductible is a set amount of money that you have to pay before we start paying for medical services and prescriptions that are covered by your plan.

Once you've met your deductible, we begin paying part of the cost for covered services. You pay the other part, which is called coinsurance. You can use your HSA money to pay your coinsurance, too. There's a limit to how much coinsurance you have to pay before we start paying for the covered services. This limit is called your out-of-pocket maximum.

If this sounds a lot different than any other kind of health plan you've had in the past, don't worry. Getting access to care from doctors and filling prescriptions is just as easy.

Getting started

Step 1: After you join the plan, you'll get your member ID card
Be sure to show the card to your doctors, pharmacy and other health care professionals when you see them.

Step 2: You can go to any doctor, pharmacy or hospital, but staying in network saves you the most money
You can visit any doctor, pharmacy, hospital or other health care provider you want. But there's a difference in the cost and how much you may have to pay.

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How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Getting care

Here's what happens when you see a network provider or pharmacy versus going out of network.

Going to a network provider or pharmacy

When you use network doctors, you usually pay less, and the office staff takes care of the paperwork for you. They'll make a copy of your ID card and send a claim to us to get paid. For covered services and prescriptions, what happens next depends on the following:

If there's enough money in your HSA, you can use your HSA debit card or check to pay your share of the cost.

What if you don't have enough money left or don't feel like using your HSA? If you haven't met your deductible for the year, you'll need to pay out of your own pocket.

After you reach your yearly deductible, traditional health coverage kicks in. That's where the plan pays part of the cost for a covered service or prescription and you pay your part (coinsurance). You pay coinsurance until you reach your plan's yearly out-of-pocket maximum. Money will be taken out of your HSA to help you pay for your coinsurance.

If you meet your yearly out-of-pocket maximum, the plan will pay 100% of the cost for your covered care or prescription, up to the allowed amount. (See your plan summary for details.)

After we look at the claim, you'll get a claim summary. It shows the total cost of the service, the allowable charge (the amount the provider agreed to accept from us) and any amount you may have to pay. If you have any out-of-pocket costs, your doctor will send you a bill for that – compare that bill to your claims summary to be sure the amounts match. That amount you pay will go toward your yearly deductible and your out-of-pocket maximum.

When you fill a prescription, show your ID card to the pharmacy staff to make sure you get the right discount for your prescription. The discount will be applied at the pharmacy and you will pay the full cost of the prescription at the time of purchase. If there's enough money in your HSA, you can use your HSA debit card or check to pay. You will not receive a claim summary for your prescription drug purchases.

Going to an out-of-network provider

You can also see provider who is not in the network, and you can still use your HSA to pay for costs. But you may have to pay the full cost of the service and then send a claim to get reimbursed.

The provider may make you pay for the bill – in full – at your appointment. If the provider doesn't send us your claim, then you'll have to do it. You can get a claim form at anthem.com. We'll apply the allowable charge on covered services toward your annual deductible and out-of-pocket maximum. The provider doesn't have to accept our allowable charge and can bill you for any difference between that charge and the total bill.

How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Getting answers

Frequently asked questions about your plan

Q: Who can open an HSA?
A: To open an HSA, you have to be:

- On a health plan that is specially made to go with an HSA. Lumenos is an example of one of these health plans. If you have any secondary coverage through your spouse's plan or an executive medical plan (which is a medical plan offered through employers to executive staff members), then that plan also has to work with an HSA.
- Joining the health plan on the first day of the month. If you join later than that, then you won't be able to put money into your HSA until the first day of the next month. But no matter when you are allowed to start putting money into your HSA, you'll be able to make the maximum annual contribution for the year.
- A U.S. resident

To open an HSA, you must not be:

- A resident of American Samoa
- Enrolled in Medicare
- Eligible to be claimed as a dependent on someone's tax return
- An active member of the military

If you're a veteran, you must not have received veterans' benefits within the last three months

Q: What's the difference between an HSA and a health care flexible spending account (FSA)?
A: You can put tax-deductible money into both HSAs and FSAs and use that money toward your medical expenses. But that's the only thing that they have in common. With an HSA, if you have money left in your account at the end of the year, you can roll it over to use toward your medical expenses for the next year. And if you were to leave your job, you could take your HSA money with you.

With an FSA, you lose any money left in your account at the end of the year. And if you leave your job, you can't take your money with you.

Q: Can I have an HSA and an FSA?
A: Yes, you can have both an HSA and an FSA. But your employer must offer one of the following:

1. **A Limited/Special Purpose FSA.** This means that you can use the FSA for dental and/or vision expenses only. Or you can use it to help pay for dependent care, like daycare expenses.
2. **Limited Purpose High-Deductible FSA.** This means that you can use the FSA for dental and/ or vision expenses. And you can use it to pay coinsurance under your health plan. Coinsurance is the amount of covered expenses that you have to pay once you've met your deductible.

How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Q: How do I put money into my HSA?
A: You fund your HSA with pre-tax and post-tax money. The easiest way is to have pre-tax money taken right out of your paycheck. But you can also put post-tax money into the account by sending a check to the address printed on your HSA checkbook. Others (like your employer or family members) may deposit money into your account as well.

Q: How much can I put into my HSA each year?
A: For 2014, if you are the only one enrolled in the HSA, the most you can put into your HSA is $3,300. If you have family coverage, you can put in $6,550. This rule is set by the IRS and U.S. Treasury. Sometimes, these annual limits can change because of inflation. Check anthem.com for the most up-to-date amounts.

Q: Can I ever put more than the annual limit into my HSA?
A: If you are 55 or older and not enrolled in Medicare, you can put in an extra $1,000 above the annual limit. When you do this, it's called a catch-up contribution. You can make catch-up contributions every year until you enroll in Medicare. Only the person who holds the HSA policy can make catch-up contributions. Amounts may be prorated if you've been enrolled in the plan for less than 12 months. You can make catch-up contributions the same way you'd make regular ones.

Q: How much can I put into my account if I open my HSA after the start of the plan year?
A: You can enroll in the HSA plan only during open enrollment or when you start a new job. Sometimes, you may have a waiting period of a couple of months for coverage to start. If you join the plan during the middle of the year, you can usually put up to the annual limit in your account – as long as you enroll by December 1. And you have to stay in the HSA and remain eligible to put money into it for the entire 12 months of the following year.

Q: What if my coverage ends before the end of the year?
A: If you leave your job, you can keep putting money into your HSA only if you still have coverage in an HSA-compatible health plan. If you aren't enrolled in one, then the annual limit amount would be pro-rated based on the number of months that you were in the HSA. If you had already put the annual limit into your account before you left your job, you'd have to withdraw any money above the pro-rated amount before the end of the tax year. And you'd have to treat that money as taxable income; otherwise you'd face tax penalties.

Q: What if my spouse has an HSA, too?
A: If you or your spouse are covered under the other one's HSA, the total amount of money in both accounts can't be more than the annual family limit.

Q: What if I have money left in my HSA at the end of each plan year?
A: Whatever you don't spend is yours to keep. You can save it in your HSA, year after year, to help you pay for future medical expenses.

Q: What kinds of health expenses does the Lumenos plan cover?
A: The Lumenos plan covers typical health expenses from office visits and prescription drugs to major surgery. These health expenses are called qualified health expenses. You can use the money in your HSA to pay your deductible and out-of-pocket maximums for these expenses. To see a list of some of the expenses covered by your plan, check your plan summary.

How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Q: How are routine checkups and health screenings (like physicals and mammograms) covered?
A: The Lumenos plan covers "preventive care" like physicals, shots and mammograms at 100% when you see a network doctor. You won't have to pay anything out of your own pocket. If you see an out-of-network doctor, you'll have to meet your deductible. If that is met, then you'll pay coinsurance. The coinsurance will go toward your out-of-pocket maximum. You can use your HSA money to cover these costs.

Q: Does the Lumenos plan cover prescription drugs?
A: Yes. You can pay for your prescription drugs with the money in your HSA. If you don't have any money left in your HSA or don't want to use that money, you will have to pay for the prescriptions out of your own pocket until you meet your deductible. After you meet the deductible amount, then you may have to pay coinsurance or a copay. To find out more about prescription coverage, see the section ***Your prescription drug plan***.

Q: Can I use HSA money to pay for health expenses that aren't covered by Lumenos?
A: Yes. These are called nonqualified expenses. They're defined in Section 213d of the IRS Code. For a list of these expenses, please visit the IRS website at irs.gov and type "Publication 502" in the search box. Keep in mind that when you use your HSA to pay for nonqualified expenses, the amount you spend will not count toward your deductible or out-of-pocket maximum. And it will be considered part of your taxable income. You will also owe a 20% penalty on the amount.

Q: Who holds the money in my HSA?
A: A qualified financial institution (like a bank) will hold and invest your money. If your employer picks a bank that we partner with, then we can take care of the enrollment for you.

Q: How do I find out my HSA balance?
A: It's easy. First register at anthem.com and then log in. Once in your account, you can see your balance and keep track of all the activity (like deposits and withdrawals) that has taken place. You can also see your health and pharmacy claims. Four times a year, we'll send you a statement that shows you all of your claims. It'll also give you any important messages about how you can improve your health and even save money.

Q: If I leave the Lumenos plan, what happens to my HSA?
A: You own your HSA. That means if you leave the Lumenos plan or your job, you can take it with you and use it for whatever you'd like. Once you retire, for example, you can use it to pay for Medicare premiums. It's up to you if you want to keep the funds in your account or roll them into a different one. If you leave them in your account, some fees will apply. You can find a list of these fees in the Health Savings Account Deposit Agreement and Disclosure Statement. Note: If you keep your HSA after leaving the Lumenos plan, you can't continue to contribute to it unless you enroll in another HSA-compatible plan.

Anthem

Lumenos® with HSA Plan Summary

The Lumenos with HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way.

Your Lumenos with HSA and Rewards Plan

First - Use your HSA to pay for covered services:

Health Savings Account

With the Lumenos with Health Savings Account (HSA), you can **contribute pre-tax dollars to your HSA**. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Contributions to Your HSA

The annual contribution maximum set by the U.S. Treasury and IRS:

$3,350 individual coverage
$6,650 family coverage

Note: These limits apply to all combined contributions from any source including HSA dollars from rewards. Rollover funds are not subject to these limits.

Plus - To help you stay healthy, use:

Preventive Care

100% coverage for nationally recommended services.

Preventive Care

No out-of-pocket costs for you as long as you receive your preventive care from a network provider. If you choose to go to an out-of-network provider, your deductible or traditional health coverage benefits will apply.

Then -

Your Deductible

The deductible is the annual amount you pay – using your HSA or out-of-pocket – before you reach the traditional health coverage portion of the plan.

Annual Deductible Responsibility

$1,300 individual coverage
$2,600 family coverage

Your **benefit period** is a calendar year or a plan year. A **calendar year** means your benefit period runs from January through December.

If needed -

Traditional Health Coverage

Similar to a PPO or HMO, after you meet your deductible, you pay coinsurance (a percentage of the provider's charges) or a copay when you visit a network provider. You'll pay more if you visit an out-of-network provider.

Traditional Health Coverage

After your deductible, the plan pays:

80% for network providers
60% for out-of-network providers

After your deductible, your coinsurance or copay responsibility is:

20% for network providers
40% for out-of-network providers

Additional protection:

For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the **plan pays 100% of the cost for covered services** for the remainder of the plan year.

Annual Out-of-Pocket Maximum

Network Providers	Out-of-Network Providers
$5,050 individual coverage	$10,000 individual coverage
$10,100 family coverage	$20,000 family coverage

Your annual out-of-pocket maximum consists of your annual deductible and your copay/coinsurance amounts.

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Rev. 10/14

If you have questions, please call toll-free 800-582-6941.

Lumenos® with HSA and Rewards Plan Summary

Overview of Covered Preventive Services

Preventive Care

Anthem's Lumenos with HSA plan covers preventive services[1] recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to help prevent avoidable premature injury, illness and death.

All preventive services received from a network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply. If you receive any of these services for diagnostic purposes — for example, a colonoscopy when symptoms are present — the appropriate plan deductible and coinsurance will apply and available account funds may be used to cover costs.

The following is an overview of the types of preventive services covered:

Child Preventive Care

Office Visits for preventive services
Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.
Immunizations:
- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer
- H. Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)

Adult Preventive Care

Office Visits for preventive services
Screening Tests for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.
Immunizations:
- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza – flu shot
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV) – cervical cancer

Summary of Exclusions or Limitations

Some covered services may have limitations or other restrictions.[2] With Anthem's Lumenos with HSA plan, the following services are limited:

Annual routine vision exam $15; not subject to deductible.

Skilled nursing facility services limited to 100 days per benefit period.

Home health care services limited to 100 visits per benefit period.

Physical and occupational therapy services limited to a combined 30 visits per benefit period.[3]

Speech therapy services limited to 30 visits per benefit period.[3]

Spinal manipulations and other manual medical intervention visits limited to 30 visits per benefit period.

Early intervention services unlimited per member per calendar year up to age 3.

Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder is unlimited per member per benefit period.

Private duty nursing limited to 16 hours per member per calendar year.

Wigs limited to 1 wig per member per calendar year.

Your Lumenos with HSA also includes **No Lifetime Maximum.**

[1] Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
[2] Additional limitations and exclusions may apply. For a complete list of exclusions and limitations, please refer to your Certificate of Coverage. Some covered services may require pre-approval.
[3] Speech, physical and occupational therapies are unlimited for Early Intervention and Autism Spectrum Disorder.

Please note: This summary is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefit levels may vary. The information included does not constitute legal, tax, or benefit plan design advice. Anthem strongly encourages consultation with a tax advisor before establishing a Health Savings Account. Any Health Savings Account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

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 is an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is 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.

Take care of yourself

Remember to get preventive care

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

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

Preventive versus diagnostic care

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

For example, say your doctor suggests you have a colonoscopy because of your age. That's preventive care. On the other hand, say your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care and you may need to pay part of the cost.

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

Child preventive care (birth through 18 years)

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

Preventive physical exams

Screening tests (depending on your age) may include

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Fluoride supplements for children from birth through 6 years old[6]
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Iron supplements for children 0-12 months[6]
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Type 2 diabetes screening
- Vision screening[2] when done as part of a preventive care visit

Take care of yourself (continued)

Immunizations

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

Adult preventive care (19 years and older)

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

Preventive physical exams

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

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- Breastfeeding support, supplies and counseling (female)[3, 4]
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Contraceptive (birth control) counseling and FDA-approved contraceptive medical services provided by a doctor, including sterilization (female), and FDA-approved prescribed or women's over-the-counter contraceptives[4, 5]
- Depression screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- HPV (female)[4]
- Intervention services (includes counseling and education):
  - Behavioral counseling to promote a healthy diet
  - Counseling related to aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79[6]
  - Counseling related to genetic testing for women with a family history of ovarian or breast cancer, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[7]
  - Counseling related to chemoprevention for women with a high risk of breast cancer

Take care of yourself (continued)

- Folic acid for women 55 years old or younger[6]
- Primary care intervention to promote breastfeeding[3,4]
- Screening and behavioral counseling related to alcohol misuse
- Screening and behavioral counseling related to tobacco use including tobacco cessation products[8]
- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for obesity
- Vitamin D for women over 65

- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)[4]
- Screening and counseling for sexually transmitted infections

Immunizations

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

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

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Customer Care number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

4. This benefit also applies to those younger than 19.

5 To get 100% coverage for birth control, you must present a prescription at an in-network pharmacy for a generic drug, a brand-name drug that doesn't have a generic equivalent, or an OTC item like female condoms or spermicide. A cost share may apply for other prescription contraceptives, based on your drug benefits.

6. To get 100% coverage, you will need to present a prescription from a doctor or other health care provider at an in-network pharmacy.

7. Check your medical policy for details.

8. For those 18 years and older. 100% coverage of tobacco cessation products requires a prescription from a doctor that must be presented at an in-network pharmacy. Coverage is provided for select generic products, brand-name products with no generic alternatives, and FDA-approved over-the-counter products.

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Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting Anthem's network with those of other Blue Cross and Blue Shield companies across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network — with just one added step.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com or call the member services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. (This is the additional step.) Call Anthem member services to verify your coverage.
3. Show your ID card at the time of service.

One additional step. No additional costs or hassles. You pay the same with any Blue Cross and Blue Shield provider as you would an Anthem network provider. Plus the provider will file your claims for you. Anthem will still mail your explanation of benefits so you can double check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.

HOME DELIVERY ORDER FORM

EXPRESS SCRIPTS®

1 Member information: Please verify or provide member information below.

Member ID:

Group:

Name:

Street Address:

Street Address:

Street Address:

City, ST, ZIP:

☐ Please send me e-mail notices about the status of the enclosed prescription(s) and online ordering at:

@ .

☐ New shipping address:

(Express Scripts will keep this address on file for all orders from this membership until another shipping address is provided by any person in this membership.)

Daytime phone:

Evening phone:

FOLD HERE

2 Patient/doctor information: Complete **one section** for each person with a prescription. If a person has prescriptions from more than one doctor, complete a new section for each doctor (additional sections are on back). Send all prescriptions in one envelope.

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

3 Complete your order: You can pay by e-check, check, money order, or credit card. Make checks and money orders **payable to Express Scripts,** and write your member ID number on the front. You can enroll for e-check payments and price medications at Express-Scripts.com, or call the Member Services phone number found on your ID card.

Number of prescriptions sent with this order:

Payment options: ☐ e-check ☐ Payment enclosed ☐ Credit card ☐ Send bill

For credit card payments:

☐ Visa ☐ MC ☐ Discover ☐ Amex ☐ Diners

Credit card number

Expiration date

M M Y Y

X

Cardholder signature

☐ I authorize Express Scripts to charge this card for all orders from any person in this membership.

☐ Rush the mailing of this shipment ($21, cost subject to change). NOTE: This will only rush the shipping, not the processing of your order. Street address is required; P.O. box is not allowed.

WLPMSNWB

Mailing instructions are provided on the back of this form.

Patient/doctor information continued

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

First name

Last name

Birth date (MM/DD/YYYY)

Sex ☐ M ☐ F

Patient's relationship to member ☐ Self ☐ Spouse ☐ Dependent

Doctor's last name

1st initial

Doctor's phone number

FOLD HERE

Important reminders and other information

Check that your doctor has prescribed the maximum days' supply allowed by your plan (not a 30-day supply), plus refills for up to 1 year, if appropriate. Also, ask your doctor or pharmacist about safe, effective, and less expensive generic drugs.

Complete the Health, Allergy & Medication Questionnaire.

There may be a limit to the balance that you can carry on your account. If this order takes you over the limit, you must include payment. Avoid delays in processing by using e-checks or a credit card. (See Section 3 for details.)

If you are a Medicare Part B beneficiary AND have private health insurance, check your prescription drug benefit materials to determine the best way to get Medicare Part B drugs and supplies. Or, call Member Services at the phone number found on your ID card. To verify Medicare Part B prescription coverage, call Medicare at 1.800.633.4227.

Express Scripts will make all possible efforts, as appropriate by law, to substitute generic formulations of medication, unless you or your doctor specifically directs otherwise.

☐ Pennsylvania and Texas laws permit pharmacists to substitute a less expensive generic equivalent for a brand-name drug unless you or your doctor directs otherwise. **Check the box if you do not wish a less expensive brand or generic drug.**

Please note that this applies only to new prescriptions and to any refills of that prescription.

For additional information or help, visit us at Express-Scripts.com or call Member Services at the phone number found on your ID card. TTY/TDD users should call 1.800.759.1089.

Federal law prohibits the return of dispensed controlled substances.

FOLD HERE

Program: <<XXXXXXXXXX>>

Place your prescription(s), this form, and your payment in an envelope. Do not use staples or paper clips.

EXPRESS SCRIPTS
PO BOX 66558
ST. LOUIS, MO 63166-6558

Ins and Outs of Coverage

Tips for understanding your coverage

Knowing the "rules of the road" for the plan you have selected can make all the difference in getting the most value from your KeyCare coverage. Here are a few tips to keep in mind when seeking services.

Services that require advance reviews

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

An explanation on how we define emergencies

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

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

USING IN-NETWORK PROVIDERS EQUALS SAVINGS

You need a checkup. Dr. Smith is an in-network doctor and he's agreed to a fee of $200 for the service. Because he's in-network, you will simply pay whatever amount you would owe under your specific benefits plan, whether it's a specific dollar amount or a percentage of what the doctor charged, like 20% of the $200. Instead you visit Dr. Jones, and he's not in our network. Dr. Jones charges $350 for a checkup. Now you will pay not only the set fee or percentage amount required under your particular benefits plan. You may also pay an additional $150 — the difference in cost between what the in-network doctor agreed to accept as a set fee compared to what the out-of-network provider charged. Same service — totally different amount that comes out of your wallet. See why it makes sense to shop around?

Note: The estimated costs are for illustrative purposes only.

The ins and outs of coverage

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

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

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

Who can be enrolled

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

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

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

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

The ins and outs of coverage (continued)

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

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

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

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

The ins and outs of coverage (continued)

Special enrollment periods

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

When you're covered by multiple plans

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

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

The ins and outs of coverage (continued)

Determining the primary versus secondary carrier

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

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	●	
	The plan with COB is		●
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	●	
	The plan covering the person as a dependent is		●
The person is the participant in two active group plans	The plan that has been in effect longer is	●	
	The plan that has been in effect the shorter amount of time is		●
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	●	
	The COBRA plan is		●
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	●	
	The non-custodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

The ins and outs of coverage (continued)

How benefits apply when Medicare-eligible

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

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

Recovery of overpayments

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

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

The ins and outs of coverage (continued)

What's not covered (exclusions)

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

acupuncture

biofeedback therapy

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

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

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

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

The ins and outs of coverage (continued)

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

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

family planning

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

services for palliative or cosmetic **foot** care

- flat foot conditions
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- foot orthotics
- subluxations of the foot
- corns, calluses and care of toenails (except as treatment for patients with diabetes or vascular disease)
- bunions (except capsular or bone surgery)
- fallen arches, weak feet, chronic foot strain
- symptomatic complaints of the feet

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

Experimental ... or not?

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

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

The ins and outs of coverage (continued)

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

hearing care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

home care services

- homemaker services
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services

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

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

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

- exercise equipment
- air conditioners, dehumidifiers, humidifiers, and purifiers
- hypoallergenic bed linens
- whirlpool baths
- handrails, ramps, elevators, and stair glides
- telephones
- adjustments made to a vehicle
- foot orthotics
- changes made to a home or place of business
- repair or replacement of equipment you lose or damage through neglect

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

The ins and outs of coverage (continued)

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

The following exceptions qualify for coverage.

For inpatients:

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

For outpatients:

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

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual deviation and dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
  - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital
  - group psychotherapy when there are more than 8 patients with a single therapist
  - group psychotherapy when there are more than 12 patients with two therapists
  - more than 12 convulsive therapy treatments during a single admission
  - psychotherapy provided on the same day of convulsive therapy

The ins and outs of coverage (continued)

nutrition counseling and related services, except when provided as part of diabetes education or when received as part of a covered wellness services visit or screening

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

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

organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

paternity testing

prescription drug benefits

- over-the-counter drugs
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the allowable charge for that prescription
- medications used to treat sexual dysfunction
- drugs for weight loss
- stop smoking aids
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- infertility medication
- any refill dispensed after one year from the date of the original prescription order

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

The ins and outs of coverage (continued)

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

private duty nurses in the inpatient setting

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

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

services or supplies

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

services or supplies

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

The ins and outs of coverage (continued)

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

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

services or benefits for:

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

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

skilled nursing facility stays

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

smoking cessation programs not affiliated with us

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

telemedicine

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

therapies

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

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

The ins and outs of coverage (continued)

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

vision services

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

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

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

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

Additional Benefits

Blue View Vision℠

Vision care is not just for eyeglass wearers. Routine eye visits are important for everyone in preventing eyesight damage. In fact, eye exams can also help detect other health problems. Blue View Vision exists so you can get the vision care you need without feeling like you're busting your budget.

Advantages of Anthem Blue View Vision:

- **You have access to eye doctors close to you.** Blue View Vision has 44,000 eye doctors and locations in its network. If you don't already have a favorite, you can quickly find one. Plus, many retail locations, like LensCrafters®, Target® Optical, Sears Optical and Pearle Vision®, are covered by the plan. Finding a Blue View Vision network provider is easy — simply visit anthem.com.
- **You can get an eye exam every year.** Not every other year like other plans. Blue View Vision helps pay for eye exams annually.
- **Not many plans are this simple.** Just schedule an appointment with a network provider and present your member ID card when you arrive. The doctor's office staff will take care of the rest. And in most instances, you just need to pay a low copayment.
- **You save even more with additional discounts.** Want a frame that costs more than your plan allows? You save 20 percent off the balance. Want spare glasses, contact lenses or prescription sunglasses? Save 15 to 40 percent. Your additional discounts are unlimited — even after your vision care benefits have exhausted.
- **You've always got someone to help.** If you're seeing your eye doctor at night or on weekends, that's when we should be available to help you. So we're open Monday through Saturday, 8 a.m. to 11 p.m. Eastern time *and* Sunday 11 a.m. to 8 p.m. Eastern time. Or you can reach the interactive voice response system most any time of the day.

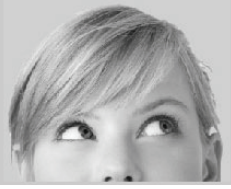
What happens if you use an eye professional not in the network?

You're still covered. You'll be asked to pay the full cost for services at the time of your appointment. When you mail in your receipt and other paperwork to Anthem, you'll get paid back for what the plan covers. To save the most money and have less hassle, try to use an eye doctor or retail location in the network.

This is a brief overview of your plan's features. Your summary of benefits contains the details. See your benefits manager if you need a copy. Thank you for considering Anthem Blue Cross and Blue Shield.

WELCOME TO BLUE VIEW VISION!

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



Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Blue View Vision℠

Exam Only A15 Plan

Your Blue View Vision network

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

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam – once every calendar year	$15 copay	$30 allowance

USING YOUR BLUE VIEW VISION PLAN

Just make an appointment for a comprehensive eye exam with your choice of any of the Blue View Vision participating eye care doctors. Your Blue View Vision plan provides services for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

As a Blue View Vision member, you can take advantage of valuable discounts through our Additional Savings program. See page 2 for further details.

OUT-OF-NETWORK

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

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

anthem.com

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

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

OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY		In-network Member Cost
Retinal Imaging	• At member's option can be performed at time of eye exam	Not more than $39
Eyeglass Frame	• When purchased as part of a complete pair of eyeglasses*	35% off retail price
Eyeglass Lenses Standard plastic material	• When purchased as part of a complete pair of eyeglasses*: - Single Vision - Bifocal - Trifocal	 $50 $70 $105
Eyeglass Lens Options and Upgrades When purchasing a complete pair of eyeglasses (frame and lenses), you may choose to upgrade your new eyeglass lenses at a discounted cost. Member costs shown are in addition to the member cost of the standard plastic eyeglass lenses.	• Standard Scratch-Resistant Coating • Tint (Solid and Gradient) • Ultraviolet (UV) Coating • Standard Polycarbonate Lenses • Standard Progressive Lenses (add on to bifocal) • Standard Anti-Reflective Coating	$15 $15 $15 $40 $65 $45
Accessories and Materials Purchased Separately Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc., and eyeglass materials if purchased separately	• As many as you like; as often as you like	20% off retail price
Conventional Contact Lenses (non-disposable type)	• Discount applies to materials only	15% off retail price
MORE SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM		**In-network Member Cost**
Laser vision correction surgery LASIK refractive surgery	• For this and other eye care and eyewear discount offers, login to member services, select discounts, then choose Vision under the Vision, Hearing & Dental tab	Discount per eye

** If frames, lenses or lens options are purchased separately, members will receive a 20% discount instead.*

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

Discounts referenced are not covered benefits under the vision plan and therefore are not included in the member's policy. Discounts are subject to change without notice.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO HealthKeepers, Inc. are independent licensees of the Blue Cross 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. 4/13

Health, Wellness & Anthem Advantages

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

Register at anthem.com today!

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

Understanding your health plan just got a whole lot easier.

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

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

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

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

To learn more visit anthem.com/costvideo.

Look up your claims

Stay on top of your medical claims with this easy online view. You can see the amounts charged to your medical savings account, the amounts paid by your traditional health coverage or how much money you'll need to pay. You may also choose to get emails when claims have been processed, instead of getting notified by regular mail.

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

Coverage Advisor℠

A customized comparison of your health care needs and costs

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

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

Find out which doctors are getting high marks from patients with the Zagat® Health Survey

You can benefit from the experiences of fellow Anthem Blue Cross Blue Shield (Anthem) members to help you find the doctor that's right for you. We've teamed up with Zagat Survey, one of the world's most trusted sources of recommendations by consumers, for consumers. Rate your doctors and also see how others have rated them as well.

Find a Doctor (dentist, pharmacy or hospital)

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

To search our online Provider Finder:

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

Print a temporary ID card

If you haven't received your permanent ID card yet and want to access health care services now, you can print your temporary ID card online.* Your temporary ID card expires 30 days after its issue date and isn't meant to replace your permanent ID card, which you'll still get in the mail.

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

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

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

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

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

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360° Health® programs

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

Your health goals and needs are as unique as you are. What's right for one person is not always right for another. Maybe you're managing a health condition. Or maybe you want to stay healthy, eat better or get in shape. Whatever your needs, Anthem gives you a choice of programs to help you meet your personal goals in a way that fits you and helps you live your life to the fullest. From tips and tools to help you learn about preventive care to nurses who can answer your health questions anytime, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

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

24/7 NurseLine

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

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you go to the emergency room or urgent care for this? Where is the nearest one?

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

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

Future Moms

If you are pregnant, we know your goal is to have a safe delivery and a healthy baby. Our Future Moms program helps you make healthy choices while you're pregnant and when you deliver your baby. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues. Our nurses will also call to see how you're doing.
- A helpful book: ***Your Pregnancy Week by Week*** and a maternity care diary.
- Tips and facts to help you handle any unexpected events.
- A questionnaire to see if you're at risk for preterm delivery.
- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks.

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative. To learn more visit anthem.com/futuremoms_video.

360° Health® programs (continued)

ConditionCare

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

Information and support are as close as your phone. Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse. To learn more visit anthem.com/conditioncare_video.

ComplexCare

ComplexCare is for our members with more than one health problem or a condition that puts them at risk for needing more care, more often.

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

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

360° Health® programs for all Lumenos Plans

Lumenos® members, looking for ways to be healthier? Just look around. Through 360° Health®, you're surrounded by tools, resources and programs that can help you and your family live healthier. Best of all, there are no additional costs. It's all part of your Lumenos plan. Get to know your health

Get to know your health

When it comes to your health, there's no such thing as too much information. And, you'll find loads of reliable health information through anthem.com. Always secure and confidential, this site also includes tools and resources to help you learn more about your health.

Find extra support when you need it the most

When it comes to tackling a health issue or reaching a health goal, there's no reason to go it alone. Recruit the assistance of a health expert who can give you the guidance you need – when you need it the most.

24/7 NurseLine

Your health concerns don't keep normal business hours. That's why 24/7 NurseLine is available to you anytime, day or night. Call the toll-free number on your ID card to talk with a nurse about a general health question or for information about an urgent health concern. Depending on your health issue, you may receive a follow-up call to make sure you've taken the necessary steps to access medical care.

Future Moms

Moms-to-be are only a phone call away from a nurse who can discuss pregnancyrelated matters. The Future Moms program also includes other prenatal goodies, such as a book about pregnancy, and a week-by-week pregnancy tracking tool.

ConditionCare

Just because you're living with a chronic condition doesn't mean you've lost control of your health. The ConditionCare program can help you better manage chronic conditions including asthma, diabetes, heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD). Our dedicated nurse coaches work with you to help you take steps toward better health.

ComplexCare

If you are dealing with a complex health issue, such as having multiple health conditions, you may like the added support offered through the ComplexCare program. Personalized nurses will help coordinate your care, offer health and lifestyle coaching, and give you strategies that will help you better manage your health.

Give us a call

For more information about 360° Health or to enroll in a specific program, call the Customer Service number on your member ID card.

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Information You Should Know

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

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

Utilization management

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

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before you get medical care)

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

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

The concurrent review (done during medical care and recovery)

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

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

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

We do a retrospective review when you have already had surgery or another type of medical care. When the UM review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically needed.

Case management

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

Preauthorization

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

Here's how getting preauthorization can help you out:

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

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

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

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

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

Your rights and responsibilities as a member

As a member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

Your rights and responsibilities as a member (continued)

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

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

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

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

HIPAA NOTICE OF PRIVACY PRACTICES

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

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

Your Protected Health Information

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

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

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

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

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which

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

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

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

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

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

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

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

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.

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

- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem, Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

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

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure. We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

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

Potential Impact of Other Applicable Laws

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

Complaints

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

Important legal information you should take time to read

Contact Information

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

Copies and Changes

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

Effective Date of this Notice

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

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

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

STATE NOTICE OF PRIVACY PRACTICES

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

Your Personal Information

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

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

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

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

You have the right to access and correct your PI.

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

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

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

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

Once you're a member, it's easy to get answers to any questions about your plan.

Just call the number on the back of your member identification (ID) card after you get it.

And Its Affiliate HealthKeepers, Inc.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for Anthem HealthKeepers plans. If you have questions, please contact your agent, Group Administrator, or member services: H-INTRO-HK (3/12), H-TOC (1/10), H-SB-POS (3/12), H-SB LUM (3/12), H-WORKS-HK (8/12), H-COVERED-HK (8/12), H-EXCL (3/12), H-CLAIMS-HK (1/12), H-COB (7/10), H-ENR (7/11), H-ENDS (7/10), H–RIGHTS (7/09), H-DEF-HK (3/12), H-EXH-A (10/10), H-INDEX (7/10) Enrollment applications used for Anthem HealthKeepers: 490760 (1/12), 490773 (1/12) This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031 Life and Disability products underwritten by Anthem Life Insurance. HealthKeepers, Inc. is an independent 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.

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

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

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