



S. W. Rodgers Company, Inc.,  
Lumenos GHSA 69

Lumenos<sup>®</sup> Medical Plan

**Take Control of Your Health**

**Your Anthem Plan**

01/01/2010

# Anthem Blue Cross and Blue Shield Lumenos Health Savings Account Plan 2000/4000 Member Booklet

This member booklet fully explains your health care benefits and how you can maximize them. Treat it as you treat the owner's manual for your car - store it in a convenient place and refer to it whenever you have questions about your health care coverage.

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

## Important phone numbers

### Member Services

800- 582- 6941



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If you need Spanish- language assistance to understand this document, you may request it at no additional cost by calling the customer service number.)

### Hours of Operation:

Monday- Friday

7:00 a.m. to 8:00 p.m. ET

Saturday

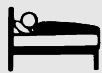
9:00 a.m. to 1:00 p.m. ET

### Visit us on- line at:

[www.anthem.com](http://www.anthem.com)



**Helpful tip:** Look for these icons to identify which services are considered inpatient and which are outpatient. The individual and family icons can be found on the Summary of benefits on page 1, and indicate the deductible and out-of-pocket expense limit amounts for each type of coverage.



Inpatient



Outpatient



Individual



Family

## Key words

There are a few key words you will see repeated throughout this booklet. We've highlighted them here to make the booklet easier to understand. In addition, we have included a **Definitions** section on page 64 that lists the various words referenced. A defined word will be italicized each time it is used.

**We, us, our, Anthem**

Anthem Blue Cross and Blue Shield.

**Covered persons**

You and enrolled eligible dependents.

**Outpatient**

When you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

**Inpatient**

When you are a bed patient in the hospital.

**You**

The enrolled employee.

**Your health plan**

Your employer's health care plan through which benefits described in this booklet are available.

**Copayment**

The fixed dollar amount you pay for some covered services.

**Coinsurance**

The percentage of the allowable charge you pay for some covered services.

**Deductible**

The fixed dollar amount of covered services you pay in a calendar year before your health plan will pay for any remaining covered services during that calendar year.

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## Summary of benefits

This chart is an overview of your benefits for covered services. They are listed in detail beginning on page 15. A list of services that are not covered begins on page 33. Please see the Out-of-network care paragraph on page 8 for more information about amounts above the *allowable charge* when services are received from non-participating *providers*.

### What will I pay?

This chart shows the most *you* pay for *deductibles* and out-of-pocket expenses for covered services in one year of coverage. All covered benefits are subject to the calendar year *deductible*; however, in-network wellness services are not subject to the calendar year *deductible*.

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

	Individual	Family	Detail Page number
			
Calendar year deductible	\$2000	\$4000	41
The most you will pay per calendar year for in-network services	\$3000	\$6000	41
The most you will pay per calendar year for out-of-network services	\$4000	\$8000	41

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

If *you* cover yourself and any other dependents, then the family *deductible* must be satisfied before any covered services are paid by the health plan. The family *deductible* may be satisfied and the family out-of-pocket expense limit may be reached by one member or all members collectively. Once the family out-of-pocket expense limit has been reached, no additional *coinsurance* will be required of the family for the remainder of the calendar year.

	Copayment	In-network Coinsurance (after calendar year deductible)	Out-of-network Coinsurance (after calendar year deductible)	Detail Page number
<b>Ambulance Travel</b> No calendar year limit (ground ambulance)	\$0	0%	0% *	15

\* Services for out-of-network ambulance providers will be subject to the in-network deductible (if any) only.

## 2 - Summary of benefits

	In- network Copayment	In- network Coinsurance	Out- of- network Coinsurance	Detail Page number
		(after calendar year deductible)	(after calendar year deductible)	
<b>Dental services</b>	\$0	0%	30%	15
<b>Diabetic equipment and education</b>	\$0	0%	30%	16
<b>Diagnostic tests</b> for specific conditions or diseases at a doctor's office, emergency room, or outpatient hospital department	\$0	0%	30%	16
<b>Dialysis treatments</b>				
<i>Facility</i>	\$0	0%	30%	17
<i>Doctor's Office</i>	\$0	0%	30%	17
<b>Doctor visits</b> on an outpatient basis	\$0	0%	30%	17
<b>Early intervention services</b> \$5,000 calendar year limit	copayment/coinsurance determined by service received.			17
<b>Emergency room visits</b>				
<i>Facility services</i>	\$0	0%	30%	18
<i>Professional provider services</i>	\$0	0%	30%	18
<b>Home care services</b> 90 - visit calendar year limit for home health services	\$0	0%	30%	18
<b>Home private duty nurses services</b> \$500 calendar year limit	\$0	0%	**	18
<b>Hospice care services</b>	\$0	0%	30%	18
<b>Hospital services</b>				
<b>Inpatient treatment</b>				
<i>Facility services</i>	\$0	0%	30%	19
<i>Professional provider services</i>	\$0	0%	30%	19
<b>Outpatient treatment</b>				
<i>Facility services</i>	\$0	0%	30%	19
<i>Professional provider services</i>	\$0	0%	30%	19
<b>Infusion services - outpatient services ***</b>				
<i>Facility services</i>	\$0	0%	30%	19
<i>Professional provider services</i>	\$0	0%	30%	19
<i>Home services</i>	\$0	0%	30%	19
<i>Infusion medications</i>				
<i>Outpatient settings</i>	\$0	0%	30%	19
<i>Home settings</i>	\$0	0%	30%	19
<b>Maternity</b>				
<b>Professional provider services</b>				
Prenatal and postnatal follow-up care	\$0	0%	30%	20
Delivery	\$0	0%	30%	20
<b>Hospital services for delivery</b> delivery room, anesthesia, nursing care for newborn	\$0	0%	30%	20
<b>Diagnostic tests</b>	\$0	0%	30%	20
<b>Medical equipment (durable), appliances, formulas, supplies, and medications</b> \$5,000 calendar year limit for medical equipment (durable)	\$0	0%	30%	21

\*\* Since there is no network required for these services, benefits will be paid as if rendered on an in- network basis.

\*\*\* See Hospital services for payment amounts for inpatient therapy.

Summary of benefits continued

	In- network Copayment	In- network Coinsurance (after calendar year deductible)	Out- of- network Coinsurance (after calendar year deductible)	Detail Page number
<b>Mental health or substance abuse treatment</b>				22
<b>Inpatient treatment</b>				22
<i>Facility services</i>	\$0	0%	30%	22
<i>Professional provider services</i>	\$0	0%	30%	22
<b>Partial day program</b>	\$0	0%	30%	22
<b>Outpatient treatment</b>	\$0	0%	30%	23
<b>Shots (injections)</b>	\$0	0%	30%	27
at a doctor's office, emergency room or outpatient hospital department				
<b>Skilled nursing facility stays</b>				28
100- day per stay limit				
<i>Facility services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<b>Spinal manipulations</b>	\$0	0%	30%	28
and other manual medical interventions \$500 calendar year limit				
<b>Surgery</b>				28
<b>Inpatient</b>				
<i>Facility services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<b>Outpatient</b>				
<i>Facility services</i>	\$0	0%	30%	28
<i>Professional provider services</i>	\$0	0%	30%	28
<b>Therapy - outpatient services ***</b>				
<b>Cardiac rehabilitation therapy</b>				
<i>Hospital services</i>	\$0	0%	30%	30
<i>Professional provider services</i>	\$0	0%	30%	30
<b>Chemotherapy</b>				
<i>Hospital services</i>	\$0	0%	30%	30
<i>Professional provider services</i>	\$0	0%	30%	30
<b>Occupational therapy visits</b>				
\$2,000 calendar year limit (combined with physical therapy visits)				
<i>Hospital services</i>	\$0	0%	30%	30
<i>Professional provider services</i>	\$0	0%	30%	30
<b>Physical therapy visits</b>				
\$2,000 calendar year limit (combined with occupational therapy visits)				
<i>Hospital services</i>	\$0	0%	30%	30
<i>Professional provider services</i>	\$0	0%	30%	30
<b>Radiation therapy</b>				
<i>Hospital services</i>	\$0	0%	30%	30
<i>Professional provider services</i>	\$0	0%	30%	30
<b>Respiratory therapy</b>				
<i>Hospital services</i>	\$0	0%	30%	30
<i>Professional provider services</i>	\$0	0%	30%	30

\*\*\* See Hospital services for payment amounts for inpatient therapy.

4 - Summary of benefits

	In- network		Out- of- network	Detail
	Copayment	Coinsurance	Coinsurance	Page number
	(after calendar year deductible)		(after calendar year deductible)	
<b>Speech therapy visits</b>				
\$500 calendar year limit				
<i>Hospital services</i>	\$0	0%	30%	30
<i>Professional provider services</i>	\$0	0%	30%	30
<b>Vision correction</b>	\$0	0%	30%	30
after surgery or accident				
<b>Wellness services</b>	\$0	0%	30%	31
for children and adults				
The calendar year deductible does not apply to wellness services received in network; however, if wellness services are received from out- of- network providers, the services will be subject to the calendar year deductible. Screenings received for diagnostic purposes (as billed by the in or out- of- network provider or facility) are not considered to be wellness services, and therefore will also be subject to the calendar year deductible.				
<b>Wigs</b>	\$0	0%	30%	32
\$500 calendar year limit				

	Copayment	Coinsurance	Detail
			Page number
<b>Prescription drugs and diabetic supplies</b>			23
All prescription drug expenses are subject to the calendar year deductible shown on page 1. Once the calendar year deductible has been satisfied, the following benefits apply:			
<b>Retail pharmacy</b>			23
covered drugs for up to a 30- day supply			
First tier	\$10	0%	23
Second tier	\$30	0%	23
Third tier	\$50	20%	23
Your payment for third tier drugs is the greater of your copayment or coinsurance and is limited to \$200 per prescription.			
<b>Mail order pharmacy</b>			25
covered drugs for up to a 90- day supply			
First tier	\$10	0%	25
Second tier	\$60	0%	25
Third tier	\$150	20%	25
Your payment for third tier drugs is the greater of your copayment or coinsurance and is limited to \$400 per prescription.			

All deductible, copayment or coinsurance amounts (if applicable) for covered prescription drugs purchased at both retail and mail service pharmacies will apply to the in- network out- of- pocket expense limit shown at the beginning of the **Summary of benefits**.

## How your health plan works

*Your health plan* provides a wide range of health care services within a special network of health care *providers* and *facilities*. You will receive benefits based on where you receive health care services and the limits stated in the Summary of benefits (see page 1) and related exclusions. *Your health plan* is a self-funded employee welfare benefit plan sponsored by your employer. The cost of your coverage, which includes the plan benefits and administrative expenses, is borne by your employer. Employees may contribute to the cost through payroll deduction. Your employer has entered into an administrative services contract with *Anthem* to carry out certain functions with respect to claims operation.

### Carry your ID card

Your Anthem Blue Cross and Blue Shield ID card identifies you as a *covered person* and contains important health care coverage information. When you show your ID card to your doctor, hospital, pharmacist, or other health care *provider*, they will file your claims for you in most cases. Carrying your card at all times will ensure you always have this coverage information with you when you need it.

### Covered providers and facilities

*Your health plan* covers certain care administered by *providers* and *facilities*. To ensure benefits, *providers* and *facilities* must be licensed in the state where they operate to perform the service you receive and the service must be covered by *your health plan*. Certain services are covered by the plan and rendered by other covered medical suppliers, such as suppliers of *medical equipment (durable)*, private duty nursing services, *prescription drugs*, ambulance services, etc.

A *provider* may delegate to his employee the responsibility for performing a covered service. *Your health plan* will cover this care if we determine that a bona fide employer-employee relationship exists, based on information given by the *provider*. Under these circumstances:

- both the *provider* and the delegated employee must be licensed/certified to render the service;
- the service must be performed under the direct supervision of the *provider* since the *provider* is primarily responsible for the patient's care; and
- the *provider* who is directly supervising the service must bill for the service.

Because the service of the delegated employee is a substitute for the *provider's* service, *your health plan* will not pay a supervisory or other fee for the same service performed by both the *provider* and his delegated employee.

## Choose a health care provider

### In Virginia

You have the freedom to receive care from any *provider* or *facility*. However, you receive the highest level of benefits when you receive care from *providers* and *facilities* within the KeyCare PPO Network. Care received from KeyCare PPO Network *providers* and *facilities* is considered in-network care. Your policy provides coverage for certain services that do not have *providers* within our networks. These services would be considered in-network services. An example is private duty nursing services.



**Helpful tip:** You may call Member Services for information regarding the qualifications of providers in the KeyCare PPO Network. Qualifications include: medical school attended, residency completed, and board certification status.

### Outside Anthem's Virginia service area - BlueCard

Anthem Blue Cross and Blue Shield does business only within a certain geographic area in the Commonwealth of Virginia. If you live or travel outside our area, you still have the freedom to receive care from any *provider* or *facility*. Keep in mind, you should receive care from a *provider* or *facility* who participates in a Blue Cross Blue Shield company's BlueCard PPO network to receive the highest level of benefits. Your health plan includes a program called "BlueCard," which provides you and your covered family members with the benefits of using selected PPO network *providers* and *facilities* outside our area. Generally, Blue Cross Blue Shield PPO network *providers* and *facilities* who participate in BlueCard will accept your copayment or coinsurance at the time of services instead of requiring full payment. Most of these *providers* or *facilities* will file claims for you and most have agreed to accept the allowable charge established by their local Blue Cross and/or Blue Shield Plan as payment in full for their services.



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

If the amount you pay for a covered service is based on the charge for that service, the charge used to calculate your part will be the lower of:

- the billed charge for the covered service; or
- the negotiated price passed on to us by the local Blue Cross and/or Blue Shield Plan. Often, this "negotiated price" will consist of a simple discounted price, but it can also be an estimated or average price allowed under the BlueCard Program and applied under the terms of your health care plan.

An estimated price takes into account special arrangements with a *provider* or *provider* group that include settlements, withholds, non-claims transactions (such as *provider* advances) and other types of variable payment. An average price is based on a discount that takes into account these same special arrangements. Of the two, estimated prices are usually closer to the actual prices. Negotiated prices may be adjusted going forward to correct for over- or underestimation of past prices. However, the amount *you* pay is considered a final price. More detailed information about negotiated prices is included in the administrative services contract.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield Plan to:

- use another method for, or
- add a surcharge to, your liability calculation.

If any state laws mandate other liability calculation methods, including a surcharge, Anthem Blue Cross and Blue Shield would then calculate your liability for any covered health care services according to the applicable state law in effect when *you* received care.

## For coverage overseas

If *you* plan to travel outside the United States, call *Anthem* Member Services and ask for the names of the participating hospitals in the area *you* will be visiting. If *you* need *inpatient* hospital care while *you're* overseas, show your ID card at the admissions office. The participating hospital will bill the plan through *Anthem* for covered expenses. *Anthem* will send benefits payments to the hospital directly. If *you* go to a non-participating hospital or receive *outpatient* care, *you* will usually have to pay the bills and submit the claims for reimbursement. However, if possible *we* will work out direct payment with the *providers*.

## How to find a provider in the network

There are four ways *you* can find out if a *provider* or *facility* is in your network:

- Refer to *your health plan's* directory of network *providers* at [www.anthem.com](http://www.anthem.com), which lists doctors and health care *facilities* that participate in *your health plan's* network, as well as information about the standards of care in area hospitals.
- Call *Anthem's* Member Services to request a list of doctors and health care *facilities* that participate with *Anthem*, based on specialty and geographic area.
- Check with your doctor or health care *facility*.
- Ask your group administrator.

All network *providers* have a process in place to help *you* access urgent medical care 24 hours a day, 7 days a week. If *you* require urgent medical care after your doctor's normal business hours call his/her office and *you* will be directed to needed care.

## Out- of- network care

*Out-of-network* care is covered at a lower level of benefits than in-network care. After *you* satisfy a calendar year *deductible* (if any), *you* are responsible for your *coinsurance*, a percentage of the *allowable charge* as stated in the Summary of benefits (see page 1). If the *out-of-network* ambulance, *provider* or *facility* participates in any *Anthem* network or other Blue Cross Blue Shield company's network, they will accept the *allowable charge* as payment in full for their services. However, ambulances, *providers* and *facilities* that do not participate in any *Anthem* or Blue Cross Blue Shield company's network may bill *you* for the difference between their charge and the *allowable charge*.

## The advance approval process

*Your health plan* will make coverage decisions on services requiring advance approval (for example, home care services, etc.), within 15 days from the receipt of the request. *Your health plan* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, *your health plan* will make its decision within 2 working days of its receipt of the medical information needed to process the advance approval request.

For *urgent care claims*, coverage decisions will be completed within 24 hours. Your physician will be notified verbally of the coverage decision within this time frame.

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

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits; and
- in the case of an *urgent care claim*, a description of the expedited review process applicable to such claims.

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

## Approvals of care involving an ongoing course of treatment

Network *providers* must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If *you* are receiving care from a non-network *provider* and need to receive an extension of a

previously approved course of treatment, you will be required to ask for the extension. You should request the extension at least 24 hours prior to the end of the authorized time frame to avoid disruption of care or services. We will notify you of our coverage decision within 24 hours of your request.

**In an emergency or if specialty care is not reasonably available in the network**

In an *emergency*, go to the nearest appropriate *provider* or medical *facility*. If the *provider* or *facility* is not in the network, you or your network physician can call *Anthem* to have the *out-of-network* services authorized for the highest level of benefits.

If specialty care is required and it's not available from a *provider* within the network, your network *provider* can call *Anthem* in advance of your receiving care to have the *out-of-network* services authorized for the highest level of benefits.

**Allowable charge**

<b>Providers or facilities</b>	<b>Allowable charge</b>
<i>providers</i> within your network	the network allowance or <i>provider's</i> charge, whichever is less
<i>providers</i> outside of your network	the participating allowance or <i>provider's</i> charge, whichever is less
network and participating <i>facilities</i>	the negotiated allowance or the <i>facility's</i> charge, whichever is less
non- participating <i>facilities</i> located in Virginia	<i>Anthem's</i> non- participating allowance or the <i>facility's</i> charge, whichever is less
non- participating <i>facilities</i> located outside of Virginia	the amount <i>Anthem</i> determines to be reasonable for the services rendered
non- provider, non- <i>facility</i> service	the amount <i>Anthem</i> determines to be reasonable for the services rendered

In the *allowable charge* chart, the allowance for covered services and the reasonable charge for covered services are determined by *Anthem* and other Blue Cross Blue Shield companies at their sole discretion.

Another Blue Cross Blue Shield company may pay a claim on our behalf to a *facility* that participates in one of its networks. When this occurs, the *allowable charge* will be the lower of the billed charges of the *facility* or the negotiated price that the Blue Cross Blue Shield company passes on to us. The negotiated price may be a simple discount of billed charges, an estimated final price that reflects future settlement with the *facility*, or an average expected savings from the *facility* or network. The estimated or average price may have been adjusted to correct for over- or under- estimation of past prices or non- claim transaction costs.

## 10 - How your health plan works

If *Anthem's* negotiated compensation cannot be determined at the time the claim for the covered service is processed, *Anthem* will use the value of the last known negotiated compensation derived from its most recent settlement with the *facility*.

### **Allowable charge for surgical services**

Surgical services performed by a *provider* are covered services. *Your health plan* will not pay separately for pre- and post-operative services.

If more than one surgical procedure is performed during the same operation, we will calculate the *allowable charge* for all of the services combined by adding:

- the *allowable charge* for the service with the highest *allowable charge*; plus
- a reduced percentage of what the *allowable charge* would have been for each of the additional surgical services if these services had been performed alone.

This is the most *your health plan* will pay during a single operation, unless extraordinary circumstances exist.

### **Assistant at surgery**

Services of a physician who actively assists the operating surgeon to perform a covered surgical service are covered services. However, when two or more surgeons provide a covered surgical service that could have been performed by one surgeon, the *allowable charge* will not be more than that available to one surgeon.

### **Anesthesia**

When surgical services require anesthesia, anesthesia services rendered by a second physician are covered services. However, when the physician performs both the surgical service and the anesthesia service, the *allowable charge* for the anesthesia services will be 50% of what it would have been if a second physician had performed the anesthesia service.

### **Hospital Admission Review**

All hospital *stays*, skilled nursing home *stays*, or treatment in partial day programs should be approved before each admission. The exception to this is maternity admissions as specified in the maternity section of this booklet. If *you* are admitted to the hospital as a result of an *emergency*, your hospital *stay* should be reviewed by *Anthem* within 48 hours of admission. The *emergency* room doctor, a relative, or a friend can call for Hospital Admission Review. Network *providers* and *facilities* handle Hospital Admission Review for *you*. *You* must initiate the Hospital Admission Review process for *out-of-network* services. If *you* fail to obtain approval for an *inpatient stay*, and the *stay* is later determined not to be *medically necessary*, *you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient*. Strict adherence to this procedure may not be required for services that arise over the weekend.

Before *you* are admitted to the hospital for medical care or surgery, *you* or someone *you* authorize must call the Member Services telephone number located on your identification card. If your *provider* is calling on your behalf, the telephone number for *providers* is 804-342-0010 in Richmond or toll-free 800-533-1120. *You* should have the following information available:

- your Anthem Blue Cross and Blue Shield identification number (shown on your ID card);
- your doctor's name and phone number;
- the date *you* plan to enter the hospital and length of *stay*; and
- the reason for hospitalization.

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

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

Once a coverage decision has been made regarding your hospital admission, *you* will receive written notification of the coverage decision. In the event of an adverse benefit determination, the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *your health plan's* appeal procedures and applicable time limits; and
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims.

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

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

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

### **Admissions to hospitals located outside of Virginia**

If *you* are admitted to a hospital outside of Virginia, *you* or someone on your behalf must initiate the Hospital Admission Review process. This applies in all cases, whether *you* live, work, or travel outside of Virginia. If approval is not obtained for an *inpatient stay* and the *stay* is later determined by *Anthem* not to be *medically necessary*, *you* may have to pay the entire hospital bill in addition to any charges for services provided while *you* were an *inpatient*.

### **Individual case management**

In addition to the covered services listed in this booklet, *your health plan* may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive covered services. This includes, but is not limited to, long term *inpatient* care. *Your health plan* will provide alternate benefits at its sole discretion. It will do so only when and for so long as it decides that the services are *medically necessary* and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If *your health plan* elects to provide alternate benefits for a *covered person* in one instance, it will not be required to provide the same or similar benefits for any *covered person* in any other instance. Also, this will not be construed as a waiver of *your health plan's* right to enforce the terms of *your health plan* in the future in strict accordance with its express terms.

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

### **If you changed plans within the year**

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

- If *you* change from one employer's health plan to another employer's health plan during the calendar year, new limitations will apply as of your *effective date* of coverage under the new employer's health plan. Amounts that may have accumulated toward similar limitations under your former employer's health plan will not count toward the limitations under your new employer's health plan.

- If you do not change employers, but move from *Anthem* HealthKeepers coverage (issued by an *Anthem* - affiliated HMO) to *Anthem* coverage during the calendar year, new limitations will apply as of the *effective date* of your *Anthem* coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket requirements under the *Anthem* HealthKeepers will not count toward the limitations under the *Anthem* coverage.
- If you do not change employers, but move from non-*Anthem* coverage (issued by any other company) to *Anthem* coverage during the calendar year, new limitations will apply as of the *effective date* of your *Anthem* coverage. Amounts that may have accumulated toward specific benefits or out-of-pocket requirements under the non-*Anthem* coverage will not count toward the limitations under the *Anthem* coverage. However, in the course of moving to *Anthem* coverage with your employer, you may be eligible for credit of deductible and/or out-of-pocket expense limit amounts accumulated under the non-*Anthem* coverage. Please see your *group administrator* for more information.
- If you do not change employers, but move from one *Anthem* benefit plan or option to another *Anthem* benefit plan or option during the calendar year, any amounts that had accumulated toward calendar year limitations before the change may count toward similar limitations under the new *Anthem* benefit plan or option for the remainder of the calendar year.

## If you have a pre-existing condition

During the first 12-months of coverage, services for *pre-existing conditions* are not covered. This is considered your pre-existing period.

The pre-existing period does not apply to:

- a child who, within 30 days after birth, is covered under any creditable coverage and who has not had a *significant break in coverage*;
- a child who is adopted or placed for adoption before attaining age 18 and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage and who has not had a *significant break in coverage*;
- pregnancy; or
- covered services for breast cancer when the *covered person* has been breast cancer free for at least five years.

We will reduce the pre-existing period by the aggregate amount of time, if any, you were covered by creditable coverage, which means coverage under any of the following:

- a group health plan;
- individual health insurance coverage;
- health insurance coverage consisting of medical care provided under any insurance policy, HMO contract, or hospital or medical service plan contract offered by a health insurer;
- Medicare, Medicaid, or Tricare;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- the Federal Employees Health Benefits Program;

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- a public health plan, which means a plan established or maintained by a state, the U.S. government, a foreign country, or a political subdivision of any of these;
- a health benefit plan under the Peace Corps Act; or
- coverage under a State Children's Health Insurance Program authorized by the Social Security Act.

So that *we* may reduce the pre-existing period by the amount of time *you* were covered under creditable coverage, *we* may require *you* to give *us* a copy of any certificates of creditable coverage that *you* have. If *you* do not have a certificate, but *you* have creditable coverage, *we* will help *you* obtain one from your prior plan or issuer. Please contact us if *you* need help demonstrating creditable coverage.

If your coverage under this health plan ends, or a covered dependent reaches the maximum age limit, *we* will issue a certificate of creditable coverage. *We* will also issue a certificate of creditable coverage upon request, as long as *you* request it within 24 months after coverage ends.

All questions about the pre-existing period and creditable coverage, as well as requests for creditable coverage certificates should be directed to Member Services at the address or telephone numbers below:

Anthem Blue Cross and Blue Shield  
Attention: Member Services  
P.O. Box 27401  
Richmond, VA 23279

Telephone:  
800- 582- 6941

If *you* have experienced a *significant break in coverage*, the previous coverage will not reduce the pre-existing period for this coverage.

*We* will not reduce the pre-existing period for any amount of time *you* were covered by:

- accident or disability income insurance, liability insurance, workers' compensation benefits, automobile medical insurance, credit insurance, or coverage for onsite medical clinics;
- another employer's waiting period;
- limited scope dental benefits, limited scope vision benefits, or long-term care benefits;
- coverage under health flexible spending arrangements that are "excepted benefits" (as defined in federal regulations); or
- health benefits that are secondary or incidental.

## What is covered

Your health plan covers only those medical services that are *medically necessary*. Just because the service is prescribed by a *provider* does not mean the service is *medically necessary*. In addition, your health plan requires that services be safely performed in the least costly *setting*.

See the **Summary of benefits** (page 1) for payment levels and limits for the covered services. For details of the specific coverage provided as well as what is not covered, use the page number references on the summary. All of the following services, except as noted, must be rendered by covered *facilities* or *providers*.

### Ambulance travel



Your health plan covers professional ambulance services to or from the nearest *facility* or *provider* adequate to treat your condition. Ambulance services billed through the *facility* are covered the same as all other *facility* services. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life. In determining whether any ambulance services will be pre-authorized, we will take into account whether appropriate, cost-effective care is being provided at the *facility* where the *covered person* is located.

### Dental services



Your health plan covers:

- *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;
- the cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth;
- the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face;
- dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer; and
- covered general anesthesia and hospitalization services for children under the age of 5, *covered persons* who are severely disabled, and *covered persons* who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the *covered person's* treating physician that such services are required to effectively and safely provide dental care.

Information about coverage for impacted wisdom teeth can be found under **Surgery**.

## Diabetic equipment and education



Your *health plan* covers medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles and syringes when purchased from a pharmacy; and
- *outpatient* self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

Diabetic education may be received from pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

## Diagnostic tests



Your benefits include coverage for the following procedures when ordered by your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms:

- radiology (including mammograms), ultrasound or nuclear medicine;
- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs; and
- advanced diagnostic imaging services.

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a hospital *stay* is covered under your *health plan* only when:

- your medical condition requires that medical skills be constantly available;
- your medical condition requires that medical supervision by your doctor is constantly available; or
- diagnostic services and equipment are available only as an *inpatient*.

*Outpatient* diagnostic imaging tools can be the key to identifying underlying health problems, but unnecessary imaging may contribute to patient safety issues: increased radiation exposure and false positive findings that may result in additional unnecessary testing and potential surgical procedures. To help ensure that you are receiving services that are safe and appropriate, we have made available a health services review process for physicians ordering these services. Health services review is a process performed in advance of receiving an outpatient advanced diagnostic imaging service. The purpose is to review for safety, appropriateness, and medical necessity, and to determine whether the service meets coverage guidelines. If your doctor orders one of the following tests for you, we suggest that you ask your doctor to initiate a health services review by contacting *Anthem*:

- magnetic resonance angiography (MRA);
- magnetic resonance imaging (MRI);
- magnetic resonance spectroscopy (MRS);
- computed tomographic angiography (CTA);
- positron emission tomography (PET) scans;
- computed tomography (CT) scans;
- single photon emission computed tomography (SPECT) scans; and

- nuclear cardiology.



**Helpful tip:** While there is no penalty if the health services review is not performed in advance of receiving the service, the advantage of the front-end review is that you and your doctor know beforehand whether the service is appropriate, medically necessary, and meets coverage guidelines. If advance approval is not obtained and the service is later determined not to be *medically necessary*, you may have to pay for the service.

Medical supplies and other services that may be required and provided in conjunction with a diagnostic test are not considered part of the diagnostic test. Therefore, if a *facility* or *provider* bills a separate charge for such services or supplies, benefits for such services or supplies will be provided as described in the **Summary of benefits** for such services and supplies and not as part of the diagnostic test.

## Dialysis



Your *health plan* covers dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

## Doctor visits and services



Your *health plan* covers:

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

## Early intervention services



Your *health plan* covers early intervention services for covered dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services ("DMH") as eligible for services under Part H of the Individuals with Disabilities Education Act. These services consist of:

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

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

## Emergency room care



Your health plan covers emergency room visits, services, and supplies. If you are admitted to the hospital from the emergency room, the hospital stays must be reviewed by Anthem within 48 hours of admission. The emergency room doctor, a relative, or a friend can call Anthem for Hospital Admission Review (see page 10) in an emergency.

## Home care services



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

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

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

## Home private duty nurse's services



Your health plan covers the cost of medically skilled services of a currently licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home when the nurse is not a relative or member of your family. Your doctor must certify to us that private duty nursing services are medically necessary for your condition, and not merely custodial in nature.

## Hospice care services



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

- skilled nursing care, including IV therapy services;
- drugs and other outpatient prescription medications for palliative care and pain management;
- services of a medical social worker;
- services of a home health aide or homemaker;
- short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the covered person in order to provide the covered person's primary caregiver a temporary break from caregiving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days;
- physical, speech, or occupational therapy (services provided as part of hospice care are not subject to dollar-limits);

- *medical equipment (durable);*
- routine medical supplies;
- routine lab services;
- counseling, including nutritional counseling with respect to the *covered person's* care and death; and
- bereavement counseling for immediate family members both before and after the *covered person's* death.

## Hospital services



Your *health plan* covers the hospital and doctors' services when you are treated on an *outpatient* basis, or when you are an *inpatient* because of illness, injury, or pregnancy. (See **Maternity** on page 20 for an additional discussion of pregnancy benefits.) Your *health plan* covers *medically necessary* care in a semi-private room or intensive or special care unit. This includes your bed, meals, special diets, and general nursing services.

In addition to your semi-private room, general nursing services and meals, your *health plan* covers *allowable charges* for *medically necessary* services and supplies furnished by the hospital when prescribed by your doctor or *provider*.

The hospital must meet the American Hospital Association's standards for registration as a hospital. Remember that your share of the cost of covered services will change if you use a doctor, *facility*, or other health care *provider* that is outside your network.

While you are an *inpatient* in the hospital, your *health plan* covers the *medically necessary* services rendered by doctors and other covered *providers*.



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

## Private room


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

## Infusion services



Your *health plan* covers infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services

include coverage of all medications administered intravenously and/or parenterally.


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

## Maternity



### Prenatal and newborn care

If *you* (or your covered spouse) become pregnant, *your health plan* provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the hospital are covered by *your health plan*.

 **Helpful tip:** See **If your family changes** on page 51 for details on when and how to enroll a newborn.

### Your benefits include:

- use of the delivery room and care for normal deliveries;
- home *setting* covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before delivery;
- hospital services for routine nursery care for the newborn during the mother's normal hospital *stay*;
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- initial examination of a newborn and circumcision of a covered male dependent;
- services for interruption of pregnancy; and
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies.

### Future Moms

*You* (or your spouse) are eligible to participate in *Future Moms*. This program is designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery. A *Future Moms* consultant is assigned to women identified as having greater risk of premature delivery. The consultant (a nurse or health educator) works with the mother and her doctor during the pregnancy to determine what may be needed to help achieve a full-term delivery. As soon as pregnancy is confirmed, sign up for the program by calling 800-828-5891. *You* will receive:

- a kit containing educational material on how to get proper prenatal care and identify signs of premature labor;
- a risk appraisal to identify signs of premature labor; and
- after delivery, a birth kit and child care book.

## Medical equipment (durable)



Your *health plan* will cover the rental (or purchase if that would be less expensive) of *medical equipment (durable)* when prescribed by your doctor. Also covered are maintenance and necessary repairs of *medical equipment (durable)* except when damage is due to neglect.

Coverage includes the following types of equipment:

- nebulizers;
- hospital type beds;
- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

## Medical devices and appliances



Your *health plan* covers the cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for *activities of daily living*:

- artificial limbs, including accessories;
- orthopedic braces;
- leg braces, including attached or built-up shoes attached to the leg brace;
- molded, therapeutic shoes for diabetics with peripheral vascular disease;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints.

## Medical formulas



Your *health plan* covers special medical formulas which are the primary source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

## Medical supplies and medications

Medical supplies are covered under *your health plan* if they are prescribed by a covered *provider*. Examples of medical supplies include:

- hypodermic needles and syringes;
- oxygen and equipment (respirators) for its administration;
- prescription medications provided by your doctor; and
- prescription medications infused through IV therapy in the physician's office or *outpatient facilities*.

Certain medical supplies may be covered under the *prescription drug* card feature of *your health plan* when purchased by *you* and supplied directly to *you* by a pharmacy. If so, these supplies will be listed and covered under **Prescription drugs** on page 23.

## Mental health or substance abuse treatment



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

### Inpatient treatment

*You* have coverage for *inpatient* care for mental health services and substance abuse services. *Your* coverage includes individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy treatment. Coverage for *inpatient mental health services* and substance abuse services is subject to the Hospital Admission Review provisions of *your health plan*. Please see Hospital Admission Review in the **How your health plan works** section for additional information. Please note that *inpatient* services for substance abuse treatment must not be merely custodial, residential, or domiciliary in nature and must be provided in a hospital or substance abuse treatment *facility* which is 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.

### Partial day services

*You* also have coverage for "partial day" mental health services and substance abuse services. Obtaining authorization in advance is recommended. A partial day program must be licensed or approved by the state and must include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance abuse, or an intensive *outpatient* program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.

## Outpatient treatment

Your coverage includes treatment for outpatient mental health and substance abuse services. Obtaining authorization in advance is recommended.

## Medication management

Visits to *your physician* to make sure that medication *you* are taking for a mental health or substance abuse problem is working and the dosage is right for *you* are covered.

## Prescription drugs and diabetic supplies



*Your health plan* covers *prescription drugs* if received through a pharmacy, a doctor's office, or a hospital.

Benefits provide for diabetic supplies to treat diabetes. This includes coverage for the following:

- home blood glucose monitors;
- lancets and test strips; and
- hypodermic needles and syringes.

Also covered are *prescription drugs* and devices approved by the Food and Drug Administration (FDA) for use as contraceptives. This includes coverage for office visits associated with contraceptive management.

If *you* receive *prescription drugs* from your doctor, they will be covered as other medical services or supplies. If *you* receive *prescription drugs* from your hospital, they will be covered as a hospital service.

## Your prescription drug benefits

Your *prescription drug* benefits cover prescriptions obtained from a pharmacist. *You* may receive up to a 30-day supply of medicine for an original prescription or refill for up to one year. Simply choose a pharmacy that participates in *Anthem's* pharmacy network and show your ID card to receive benefits. Your *prescription drug* benefits are subject to the calendar year *deductible*. If *you* have not satisfied the *deductible*, *you* should expect to pay for your prescription when *you* pick it up from the pharmacy.

To avoid the expense of amounts above the *allowable charge*, simply choose a pharmacy that participates in *Anthem's* pharmacy network. To find a pharmacy that participates in *Anthem's* pharmacy network *you* should:

- refer to *your health plan's* directory of network *providers* at [www.anthem.com](http://www.anthem.com), which lists pharmacies that participate in *Anthem's* pharmacy network;
- check with your local pharmacy to see if they participate in *Anthem's* pharmacy network; or
- call *Anthem's* Member Services.

*Anthem's* network pharmacies, available nationwide, will automatically file claims for *you* and charge *you* only the required *deductible* and *copayment* or *coinsurance* amounts under your health care plan for covered prescriptions.

From time to time *we* may initiate various programs to encourage *covered persons* to utilize more cost-effective or clinically-effective drugs including, but not limited to, generic drugs, mail order drugs, over-the-counter (OTC) drugs, or preferred products. Such programs may involve reducing or waiving *copayments* or *coinsurance* for certain drugs or preferred products for a limited period of time.

*You* must have used 75% of your prescription before it can be refilled. However, in the following circumstances, *you* can obtain an additional 30-day supply from your pharmacist:

- you've lost your medication;
- your medication was stolen; or
- your physician increases the amount of your dosage.

*Anthem* Blue Cross and Blue Shield receives financial credits from drug manufacturers based on the total volume of claims processed for their products utilized by *Anthem* members. A portion of these credits are used to reduce plan costs and a portion is used by *Anthem* as part of its fee for administering the program. Reimbursements to pharmacies are not affected by these credits.

### **First- tier, second- tier, and third- tier drugs**

Once *you* have satisfied the calendar year *deductible*, the amount *you* will pay for a *prescription drug* depends on whether the drug *you* receive is a *first-tier*, *second-tier*, or *third-tier drug*. Refer to the **Summary of benefits** to determine your *deductible* (if any) and *copayment* or *coinsurance* amounts. *Prescription drugs* will always be dispensed as ordered by your physician. *You* may request, or your physician may order, the brand name drug. By law, generic and brand name drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. *We* reserve the right, in *our* sole discretion, to remove certain higher cost generic drugs from this policy.

Your *prescription drug* benefit includes the Half- Tablet Program. After *you* have satisfied the calendar year *deductible*, this program will allow *covered persons* to pay a reduced *copayment* on selected "once daily dosage" medications. The Half- Tablet Program allows *you* to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the physician to take "½ tablet daily" of those medications on the approved list. The National Pharmacy and Therapeutics (P&T) Committee will determine additions and deletions to the approved list. The Half- Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your physician. To obtain a list of the products available on this program contact 800-962-8192.

*We* have established a National P&T Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining whether a drug will be included in the *Anthem* Formulary;

determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of tier assignments and formulary inclusion are made by *Anthem* based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability; the degree of utilization of one drug over another in *Anthem's* patient population; and where appropriate, certain clinical economic factors.

We retain the right at *our* discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another tier.

### **When you may need to file a claim**

You may need to file your own claim if:

- your prescription is filled by a non-participating pharmacy;
- you need to have a prescription filled before you receive your card; or
- you have a prescription that requires special prior approval, but you need the prescription filled immediately.

Contact *Anthem's* Member Services if you need a Direct Member Reimbursement Claim Form or if you have any questions about your drug program and related procedures.

### **To file a claim, follow these 3 steps:**

1. complete the Direct Member Reimbursement Claim Form. If possible, ask the pharmacist to complete the pharmacy section of the form and sign;
2. pay for the prescription; and
3. mail your claim form to the address on the back of the form within 15 months of purchasing the prescription.

### **Maintenance medications**

You may also purchase covered *maintenance medications* through the mail from WellPoint NextRx Pharmacy (NextRx), in *Anthem's* mail order pharmacy network, and your prescription will be delivered directly to your home. To receive your *maintenance medicine* prescription by mail, follow these 3 steps:

1. ask your doctor to prescribe a 90-day supply of your *maintenance medicine* plus refills. If you need the medicine immediately, ask your doctor for two prescriptions: one to be filled right away and another to send to NextRx.
2. complete the NextRx Patient Profile Questionnaire which is enclosed within the NextRx envelope. This is needed for your first order only.
3. mail your questionnaire, written prescription(s), and a check to cover the amount of your *coinsurance* or *copayment(s)* to NextRx.

You will receive your *prescription drugs* via first class mail or UPS approximately 14 days from the date you sent your order.



**Helpful tip:** We suggest that you order your refill two weeks before you need it to avoid running out of your medication.



**Helpful tip:** If you have questions concerning the mail order program you can call Member Services at 800- 582- 6941.

You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, *you* must have used 75% of your prescription. Mail the refill notice and the appropriate *coinsurance* or *copayment* amount to NextRx in the envelope provided.

### Specialty medications under your prescription drug card benefit

Members who use certain covered specialty drugs must purchase them through PrecisionRx Specialty Solutions, *Anthem's* specialty pharmacy network. *You* may obtain a list of specialty drugs available through the specialty pharmacy by contacting Member Services or online at [www.anthem.com](http://www.anthem.com). These specialty drugs will be covered only when obtained through this network. Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. The specialty pharmacy will fill both retail and mail order prescriptions, although the ability to provide a 90-day supply of a specialty drug may be limited by the storage requirements of that particular drug.

The specialty pharmacy provides dedicated patient care coordinators to help *you* manage your condition and toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications. *You* or your doctor can order your specialty medication direct from the specialty pharmacy by simply calling 1-800-870-6419. *You* will be assigned a patient care coordinator who will work with *you* and your physician to obtain prior authorization and to coordinate the shipping of your medication directly to *you* or your physician's office. Your patient care coordinator will also contact *you* directly when it is time to refill your prescription.

### Services of non- participating pharmacies

Notwithstanding any provision in this booklet to the contrary, *you* have coverage for *outpatient* prescription drug services provided to *you* by a non-participating pharmacy that has previously notified *Anthem* of its *agreement* to accept reimbursement for its services at rates applicable to *Anthem* specialty pharmacy network providers including any applicable *copayment*, *coinsurance* and/or *deductible* (if any) amounts as payment in full to the same extent as coverage for *outpatient* prescription drug services provided to *you* by *Anthem* specialty pharmacy network providers. Note, however, that this

paragraph shall not apply to any pharmacy which does not execute a participating pharmacy *agreement* with *Anthem* or its designee within thirty days of being requested to do so in writing by *Anthem*, unless and until the pharmacy executes and delivers the agreement.

If *you* have a prescription filled at a non-participating pharmacy, *you* must complete and submit a claim to *Anthem's* pharmacy network. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. If *you* have questions or need a claim form, call Member Services or *visit our* website at [www.anthem.com](http://www.anthem.com).

### **Prior authorization**

*Your health plan* requires prior review of selected formulary drugs as well as non-formulary drugs before payment is authorized; for example, growth hormones. Your doctor has a list of drugs that require special approval. This list is periodically modified. *You* may obtain a copy of this list by simply contacting Member Services or from the Internet at [www.anthem.com](http://www.anthem.com). Your doctor or pharmacist should submit a request that includes the drug name, quantity per day and strength, period of time the drug is to be administered, medical condition for which the drug is being prescribed, the patient's name, ID number, date of birth, and relationship to the employee. The request, along with applicable medical records, may be submitted in writing, by telephone, or by fax to:

WellPoint Next Rx  
Drug Prior Authorization  
P. O. Box 746000  
Cincinnati, OH 45274

Telephone:  
800-338-6180  
Fax:  
800-601-4829

*You* will receive a written notice when a prescription is denied for coverage. Your doctor will be notified of both approval and denial decisions.

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

### **Shots (Injections)**



*Your health plan* covers therapeutic injections (shots) that a *provider* gives to treat illness (e.g., allergy shots) or pregnancy-related conditions. Also included is allergy serum for allergy shots. In addition, *you* have coverage for immunizations and self-administered injections.

Some injections may be administered by pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

## Skilled nursing facility stays



Your coverage includes benefits for skilled nursing home *stays*. Coverage for your *stay* requires prior approval. Your doctor must submit a plan of treatment that describes the type of care *you* need. The following items and services will be provided to *you* as an *inpatient* in a skilled nursing bed of a *skilled nursing facility*:

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

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

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

## Spinal manipulation and other manual medical interventions



*Your health plan* covers spinal manipulation services (manual medical interventions) and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations such as massage and myofascial release.

## Surgery



### General surgery

Surgery charges are covered when treatment is received at an *inpatient*, *outpatient* or ambulatory surgery *facility*, or doctor's office. *Your health plan* will not pay separately for pre- and post-operative services.

### Reconstructive breast surgery and mastectomy

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

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; and

- prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the *covered person*.

Reconstructive breast surgery done at the same time as a mastectomy or following a mastectomy to reestablish symmetry between two breasts is also covered.

## Oral surgery

Your *health plan* covers oral surgery for:

- surgical removal of impacted wisdom teeth;
- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction;
- orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part;
- surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures; and
- the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

## Organ and tissue transplants, transfusions

Your *health plan* covers organ and tissue transplants and transfusions. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health plan.



**Helpful tip:** Certain organ or tissue transplants are considered *experimental/investigative* or not *medically necessary*. You may wish to contact Member Services or have your provider initiate the pre- authorization process to determine if a specific transplant will be covered.

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.

## Therapy



Your *health plan* covers the following therapies when the treatment is *medically necessary* for your condition and provided by a licensed therapist:

### **Cardiac rehabilitation therapy**

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

### **Chemotherapy**

*Your health plan* covers the treatment of disease by chemical or biological antineoplastic agents.

### **Occupational therapy**

*Your health plan* covers occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

### **Physical therapy**

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

### **Radiation therapy**

*Your health plan* covers radiation therapy including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

### **Respiratory therapy**

*Your health plan* covers respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

### **Speech therapy**

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

### **Vision correction after surgery or accident**



*Your health plan* covers the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

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

## Wellness services



*Your health plan* provides for preventive services for children and adults, including screenings, immunizations and other services to detect medical conditions in advance. The preventive services listed below are covered. The list has been developed taking into account the recommendations of the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics, and for childhood immunizations, as prescribed by the Commissioner of Health.

When you receive covered wellness and preventive services from in-network *providers*, the calendar year *deductible* will not apply to the services. If wellness services are received from *out-of-network providers*, the services will be subject to the calendar year *deductible*. Sometimes 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*. If any of the services are considered diagnostic and/or surgical, rather than screening, then the calendar year *deductible* and *coinsurance* will apply.

In addition to the office visits that accompany these services, the following screening tests are included:

- eye chart vision screening (full vision exams are not included unless *your health plan* includes a routine vision benefit);
- hearing screening;
- screening for lead exposure (as recommended for children);
- cholesterol and lipid level screening;
- blood glucose test to screen for Type II diabetes;
- prostate cancer screenings including digital rectal exam and PSA test;
- pelvic exam, Pap test (performed by any FDA-approved gynecologic cytology screening technologies), and contraceptive management for females;
- breast exam and mammography screening;
- screening for sexually transmitted diseases;
- HIV test;
- bone density test to screen for osteoporosis;

## 32 - What is covered

- colorectal cancer screening including fecal occult blood test, barium enema; flexible sigmoidoscopy, and screening colonoscopy;
- routine blood and urine screenings.

Coverage for the following immunizations is also included, in accordance with the recommendations of the previously mentioned organizations:

- Hepatitis A;
- Hepatitis B;
- Diphtheria, tetanus, pertussis (DtaP) as appropriate for infants and children;
- Tetanus, diphtheria (Td) as appropriate for adults;
- Varicella (chicken pox);
- Influenza (flu shot);
- Pneumococcal conjugate (pneumonia);
- Human papilloma virus (HPV);
- H. Influenza type b as appropriate for infants and children;
- Polio as appropriate for infants and children;
- Measles, mumps, rubella (MMR);
- Meningococcal polysaccharide;
- Rotavirus as appropriate for infants and children; and
- Herpes zoster (shingles) as appropriate for adults.

### Wigs



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

## What is not covered (Exclusions)

This list of services and supplies that are excluded from coverage by *your health plan* will not be covered in any case.

### A

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

### B

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

### C

Your coverage does not include benefits for:

- over the counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags; or
- benefits for, or related to, **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.

### D

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

- treatment of natural teeth due to diseases;
- treatment of natural teeth due to accidental injury occurring on or after your *effective date* of coverage, unless treatment was sought within 60 days after the injury and you submitted a treatment plan to *Anthem* for prior approval;
- 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;
- 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.

## 34 - What is not covered

This exclusion will not apply if your group's coverage includes a dental rider.

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

### E

Your coverage does not include benefits for **educational** or teacher services except as specified in this booklet.

Your coverage does not include benefits for **experimental/investigative** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer. The criteria for deciding whether a service is experimental/investigative or a clinical trial cost for cancer is set forth in **Exhibit A**.

### F

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

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

Your coverage does not include benefits for palliative or cosmetic **foot** care including:

- 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;
- bunions (except capsular or bone surgery);
- calluses;
- care of toenails;
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

## H

Your coverage does not include benefits for **health club memberships**, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Your coverage does not include benefits for **hearing care** except as defined on page 31 of this booklet. Your coverage also does not include benefits for implantable or removable hearing aids, with the exception of cochlear implants.

Your coverage does not include benefits for the following **home care** services:

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

Your coverage does not include benefits for the following **hospital** services:

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

## M

Your coverage does not include **maternity** benefits for your unmarried dependent children.

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

- 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; or
- repair or replacement of equipment you lose or damage through neglect.

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

## 36 - What is not covered

Your coverage does not include benefits for services and supplies if they are deemed not **medically necessary** as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent you from appealing Anthem's decision that a service is not *medically necessary*.

However, if you receive *inpatient* or *outpatient* services that are denied as not *medically necessary*, or are denied for failure to obtain the required pre-authorization, the following professional provider services that you receive during your *inpatient stay* 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:

For inpatients

1. services that are rendered by professional providers who do not control whether you are treated on an *inpatient* basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.
2. services rendered by your attending provider other than *inpatient* evaluation and management services provided to you. *Inpatient* evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. *Inpatient* evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

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

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

- *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; or
- 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; or
  - psychotherapy provided on the same day of convulsive therapy.

## N

Your coverage does not include benefits for **nutrition** counseling and related services, except when provided as part of diabetes education.

Your coverage does not include benefits for **nutritional and/or dietary supplements**, except as provided under *your health plan* 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.

## O

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

Your coverage does not include benefits for **organ** or tissue transplants, including complications caused by them, except as outlined on page 29 of this book.

## P

Your coverage does not include benefits for **paternity testing**.

Your **prescription drug** benefit does not include coverage for:

- 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 (see page 70);
- cost of medicine that exceeds the *allowable charge* for that prescription;
- drugs for weight loss;
- stop smoking aids;
- therapeutic devices or appliances;
- injectable *prescription drugs* that are supplied by a *provider* other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed *provider*;
- any refill dispensed after one year from the date of the original prescription order;
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or
- medicine furnished by any other drug or medical service.

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

## R

Your coverage does not include benefits for rest cures, custodial, **residential**, or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services.

Your coverage does not include benefits for care from a **residential treatment center** or other non-skilled settings, except to the extent such setting qualifies 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.

## S

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

- ordered by a doctor whose services are not covered under *your health plan*;
- care of any type given along with the services of an attending *provider* whose services are not covered;
- 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;
- for travel, whether or not recommended by a physician;
- given by a member of the covered person's immediate family;
- provided under federal, state, or local laws and regulations. This includes 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;
- received from an employer mutual association, trust, or a labor union's dental or medical department; or
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

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

Your coverage does not include benefits for:

- amounts above the *allowable charge* for a service;
- self-administered services or self-care;

- self-help training; or
- biofeedback, neurofeedback, and related diagnostic tests.

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

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

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

Your coverage does not include benefits for services related to **smoking cessation**, including stop smoking aids or services of stop smoking clinics.

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

## T

Your coverage does not include benefits for the following **therapies**:

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

## V

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

- vision services or supplies unless needed due to eye surgery and accidental injury;
- services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. 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 of any type;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- any other vision services not specifically listed as covered.

## W

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

Your coverage does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. 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.

## Claims and payments

Your *health plan* considers the charge to be incurred on the date a service is provided. This is important because *you* must be actively enrolled on the date the service is provided. Also, the dates of service will affect your *deductible* (if any) and other minimums described in the **Summary of benefits** and in this section.

### Calendar year deductible

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

### Limits on your out-of-pocket expenses

Your *health plan* protects *you* from large out-of-pocket expenses by limiting the amount *you* spend out of your own pocket each year. Once the limit on your *health plan* is reached, almost all other covered expenses are paid in full for the rest of the calendar year.

### What you will pay

#### In-network limit

*Deductible* amounts for in-network and *out-of-network* services as well as *coinsurance* for services by *providers* and *facilities* within your network count toward your in-network, out-of-pocket expense limit. *Deductible* and *coinsurance* amounts for *prescription drugs* under your *prescription drug* benefit will always apply toward the *in-network* limit, even when your prescription is filled by a pharmacy outside *Anthem's* pharmacy network. When your in-network, out-of-pocket expense limit is reached, *deductibles* and *coinsurance* for in-network services will no longer apply for the rest of the calendar year. Two special situations when expenses will also count toward this limit are:

- when *you* receive services from medical suppliers for whom there is no network (e.g., private duty nurses), your out-of-pocket expenses count toward this limit; and
- when specialty care is not available within the network and *Anthem* authorizes the highest level of benefits, any *deductibles* and *coinsurance* for these covered services count toward this limit.

### **Out-of-network limit**

*Deductible* amounts for in-network and *out-of-network* services as well as *coinsurance* for covered services by *providers* and *facilities* who are not part of your *KeyCare PPO Network*, but who participate in an *Anthem* or Blue Cross and Blue Shield Company's network, count toward your *out-of-network*, out-of-pocket expense limit. If you reach your *out-of-network*, out-of-pocket expense limit, you will no longer pay *coinsurance* for *out-of-network* services for the rest of the calendar year.

### **What does not count toward these limits**

The following amounts do not count toward your out-of-pocket expense limit, and you will always be responsible for these expenses, regardless of whether you have met your out-of-pocket expense limit.

- amounts above the *allowable charge* (these amounts are not the patient's responsibility when services are rendered by a network or participating *provider* or *facility*);
- amounts above health plan limits;
- expenses for supplies or services not covered by your *health plan*; or
- *deductible*, *copayments*, and *coinsurance* for dental services provided by separate contract, certificate, or amendment to this health plan.

### **How Anthem pays a claim**

#### **Network and participating providers and facilities**

If you go to a network or participating *provider* or *facility*, we will pay the *provider* or *facility* directly. If *coinsurance* or a *copayment* is applicable to covered services rendered by a network or participating *facility* or *provider*, or if any applicable *deductible* is not met, any such amounts may be collected at the time of service. Any applicable *coinsurance* is based on *Anthem's* negotiated payment arrangement with the *facility* or *provider*.

#### **Non-participating providers and facilities**

If you go to a non-participating *provider* or *facility*, we may choose to pay you or anyone else responsible for paying the bill. We will pay only after we have received an itemized bill or proof of loss and all the medical information we need to process the claim. We will not pay a non-participating *provider* more than we would have paid a participating *provider* for the same service.

In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-participating *provider*. In all cases, our payment relieves *Anthem* and your *health plan* of any further liability for the service.

## When you must file a claim

Network *providers* file claims on your behalf. *You* may have to file a claim if *you* receive care from a *provider* or *facility* that does not participate in *Anthem's* network.

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

1. Call 800- 582- 6941 to order a claim form or get one from your *group administrator*.
2. Please include the completed and signed claim form and any itemized bills for covered services. Each itemized bill must contain the following:
  - name and address of the person or organization providing services or supplies;
  - name of the patient receiving services or supplies;
  - date services or supplies were provided;
  - the charge for each type of service or supply;
  - a description of the services or supplies received; and
  - a description of the patient's condition (diagnosis).

In addition, private duty nursing bills must include the professional status of the nurse (for example, RN for registered nurse), the attending physician's written certification that the services were *medically necessary*, and the hours the nurse worked.

3. Send the completed claim form and any itemized bills for covered services to:
 

Anthem Blue Cross and Blue Shield  
P. O. Box 27401  
Richmond, VA 23279

## Timely filing of claims

Written proof of loss must be furnished within 90 days after the date of service. A proof of loss is not complete unless it is properly filed and contains all information that *Anthem* needs to process the claim. Failure to furnish the proof of loss within this time frame will not invalidate or reduce any claim if the proof of loss is given as soon as reasonably possible. However, no claim will be paid if we receive the proof of loss more than 15 months after the date of service, except in the absence of legal capacity of the *covered person*.

## When your claim is processed

In processing your claim, *your health plan* may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the “**When you must file a claim**” paragraph of this section will be processed within 30 days of receipt of the claim. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond *our* control. In the event that this extension is necessary, *you* will be notified prior to the expiration of

the initial 30-day period. If the coverage decision involves a determination of the appropriateness or medical necessity of services, *we* will make our decision within 2 working days of *our* receipt of the medical information needed to process the claim.

*Your health plan* may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by *you* or your *provider* furnishing the additional information. *You* or your *provider* must submit the additional information to *us* within either 15 months of the date of service or 45 days from the date *you* were notified that the information is needed, whichever is later. Once your claim has been processed by *your health plan*, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination*, the written notification will include the following:

- the specific reason(s) and the plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed; and
- a description of *your health plan's* appeal procedures and applicable time limits.

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

## Recovery of overpayments

*Anthem* shall have the right to recover any overpayment of benefits from persons or organizations that *we* have determined to have realized benefits from the overpayment:

- any person to, or for whom, such payments were made;
- any insurance company;
- a facility or provider; or
- any other organization.

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

## When you are covered by more than one health plan

### Coordination of benefits (COB)

All benefits provided under this health plan are subject to special coordination of benefits (COB) rules that apply when *you* or members of your family have additional health care coverage through other group health plans. Benefits will not be increased by this COB provision, and this provision applies if the total payment under this plan, absent this provision and under any other contract, is greater than the value of covered services. Other coverage means any arrangement providing health care benefits or services, including:

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

If there is more than one form of other coverage, this provision will apply separately to each. If the other coverage has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

*Anthem* will not determine the existence of any other coverage, or the amount of benefits payable under any other coverage except this health plan. The payment of benefits under this health plan shall be affected by the benefits payable under other coverage only when *Anthem* is given information about the other coverage.

If the rules of this health plan and the other coverage both provide that this health plan is primary, then this health plan is primary. When *Anthem* determines that this health plan is secondary under the rules described below, benefits will be reduced so that our payment plus the other contract's payment will not exceed *Anthem's allowable charge* for covered services.

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

### Primary coverage and secondary coverage

When a *covered person* is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the following order of benefit determination rules:

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- If coverage under a contract is taken out in the name of a covered person, then that contract will be primary for that covered person. However, if the person is also entitled to Medicare, and as a result of federal law Medicare is:
  - secondary to the contract covering the person as a dependent; and
  - primary to the contract covering the person as other than a dependent (e.g. a retired employee);
- then the benefits of the contract covering the person as a dependent are determined before those of the contract covering the person as other than a dependent.
- For children who are covered under both parents' contracts, the following will apply:
  - The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
  - When parents are separated or divorced, the following special rules will apply:
    - If the parent with custody has not remarried, that parent's contract will be primary.
    - If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
- The rules listed above may be changed by a court decree:
  - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
  - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.
  - If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.
  - If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his dependent) will be primary. The policy or plan of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.
- If another policy or plan has different rules from those listed above other than the gender rule, that policy or plan will be primary.

When this health plan provides secondary coverage, we first calculate the amount that would have been payable had this health plan been primary. In no event will this health plan's payment as secondary coverage exceed that amount. This health plan coordinates benefits so that the combination of the primary plan's payment and this health plan's payment does not exceed *our* allowable charge. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.

The preceding paragraph does not apply to claims for *outpatient prescription drugs* provided by a pharmacy when Medicare Part D provides the covered person's primary prescription drug coverage. See the following section for more information.

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

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

## Right of recovery provision

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

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

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

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

The *covered person* acknowledges that this plan's recovery rights are a first priority claim against all potentially responsible parties and are to be paid to *the plan* before any other claim for the *covered person's* damages. This plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the plan will result in a recovery to the *covered person* which is insufficient to make the *covered person* whole or to compensate the *covered person* in part or in whole for the damages sustained. It is further agreed that the plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the *covered person* to pursue the *covered person's* damage claim.

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

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

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

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

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

## Changing your coverage

### Who is eligible for coverage

#### You

*You* are eligible for coverage after *you* satisfy your employer's eligibility requirements. Eligibility requirements are available from your *group administrator*. Your employer will inform *you* of your *effective date* in accordance with these eligibility requirements.

#### Your eligible dependents

Eligible dependents include:

- Your spouse;
- Your unmarried children age 19 or younger; or your unmarried children age 23 or younger who are full-time students which includes:
  - a newborn, natural child, or a child placed with *you* for adoption;
  - a stepchild who receives more than one-half of his or her support from *you*; or
  - any other child for whom *you* have legal guardianship or court-ordered custody, provided that the child receives more than one-half of his or her support from *you*.

The age limit for enrolling a child is age 19. Coverage for children will end on the last day of the calendar year in which the children reach age 19.

The age limit for enrolling a child who is a full-time student is age 23. Coverage for full-time students will end on the last day of the calendar year in which the children reach the specified age limit or the last day of the month in which they stop attending school full-time, whichever occurs first. In the event the child ceases to be a *full-time student* because of a medical condition, the child's coverage under the health plan will continue for a period of not more than 12 months from the date the child ceases to be a *full-time student*, or the child attains age 25, whichever occurs first. The child's treating physician must certify to us at the time the child withdraws as a *full-time student* that the absence from school is *medically necessary*.

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

*You* may be asked to provide a physician's certification of the dependent's condition.

## Types of coverage

Your employer provides the following enrollment options. After reviewing the available options, *you* may choose the option that best meets your needs. The options are as follows:

- Employee only
- Employee and spouse
- Employee and one child
- Employee and family

## When you may enroll

*You* may enroll:

- **During the initial enrollment period**

If your employer has purchased a new group policy from *Anthem* and *you* were enrolled under a previous group policy of that employer on the date before this group policy is effective, your *effective date* will be the date the health plan begins. Your *group administrator* can tell *you* what this date is.

- **Within 31 days after becoming eligible**

Your *effective date* will be determined by your employer in accordance with its eligibility requirements.

- **During annual open enrollment periods**

Your employer will tell *you* the *effective date* if *you* enroll during your company's annual open enrollment period.

- **During a special enrollment period**

*You* may have chosen to decline coverage for yourself and/or dependents under this health plan when *you* could have enrolled for it because of coverage under another health plan.

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

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

- for a dependent, cessation of dependent status.

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

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

Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/SCHIP or of the eligibility determination.

## If your family changes

Special enrollment periods are also allowed if your family changes. The change may be due to your marriage, the birth of a child, or the placement of a child with *you* for adoption. Within 31 days after the change occurs, *you* will need to complete an application to add dependents or a change form to delete dependents. In all cases, contact your *group administrator* immediately.

### Marriage

The *effective date* of coverage for those added as a result of marriage will be determined by your employer in accordance with its eligibility requirements.

### Newborn and adopted dependents

If *you* enroll a newborn dependent during the special enrollment period following his or her birth, the newborn's coverage will begin on his or her date of birth. If *you* enroll a dependent placed with *you* for adoption during the special enrollment period following his or her placement, the dependent is covered from the date of placement. If a newborn is placed for adoption within 31 days of birth, coverage is effective from the moment of birth.

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

## After coverage ends

When a *covered person* ceases to be eligible or the required premiums are not paid, the *covered person's* coverage will end. When coverage is ending due to loss of eligibility, the date that coverage will end will be determined by the employer in accordance with its eligibility requirements. When coverage is ending due to lack of premium payment, coverage will end the last day of the month for which payment is made.

Examples of when a *covered person's* eligibility may cease include:

- when *you* leave your job with the employer.
- when a dependent child reaches the end of the year in which the child turns 19.
- when a child who is a full-time student reaches the end of the year in which the child turns 23 or the last day of the month in which the child stops going to school full-time, whichever occurs first. Special rules apply when a dependent ceases to be a *full-time student* for medical reasons. Please refer to page 49 for information about when eligibility ceases for these dependents. Coverage will end on the last day of the month in which eligibility ceases.
- in the case of a handicapped dependent, when the child is no longer handicapped.
- when a dependent child marries.
- in the case of your spouse, when *you* and your spouse divorce.

## After you become eligible for Medicare

If *you* continue to work after becoming eligible for Medicare due to age (usually at age 65), your Medicare entitlement will not end your eligibility for coverage under this health plan. When *you* retire, *you* will no longer be eligible for coverage under the group plan. *You* may be able to apply for a COBRA continuation of coverage (see “Continuation of Coverage (COBRA)” section below). If *you* are entitled to Medicare, *you* may also be eligible for an individual Medicare supplement plan.

To enroll for Medicare when *you* or a family member becomes eligible for it, *you* must contact the nearest Social Security Office.

## When the employee dies

Coverage continues until the last day of the month in which the employee's death occurs unless your family member(s) are eligible for and elect continuous coverage. (See **Continuation of coverage (COBRA)** below.) Your family members are also eligible for an individual policy through *Anthem*.

## Continuing coverage when eligibility ends

*You* and your covered dependents may be eligible for the following:

- continuous group coverage under the COBRA law (Consolidated Omnibus Budget Reconciliation Act); or

- individual coverage through *Anthem*.

## Continuation of coverage (COBRA)

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

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

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

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

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

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

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

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

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

When the *qualifying event* is:

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

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

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

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

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

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

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

A *qualified beneficiary's* eligibility for COBRA coverage will end on the earliest of the following dates:

- the date that ends the maximum continuation period described above;
- the date that ends the last period for which a monthly payment was made when due;
- the date the *qualified beneficiary* obtains coverage under any other group health plan that does not contain an exclusion or limitation that is applicable to his or her pre-existing conditions;
- the date the *qualified beneficiary* becomes enrolled in Medicare; or
- the date the employer's group health plan ends.

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

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

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

## **Switching to individual coverage**

Contact *Anthem* within 31 days of the day coverage ends to prevent a lapse in coverage. If *you* meet enrollment requirements for an individual plan and apply within 31 days, there will be no lapse in coverage. Otherwise, claims may not be paid for a period of time. To make sure *you* know what will be covered, read the individual *Anthem* offer carefully. It will outline:

- enrollment rules;
- the time permitted to accept the offer;
- the waiting period, if any; and
- the benefits and rates of the individual plan.

## Important information about your health plan

### Statement of ERISA rights

As a participant in this plan *you* are entitled to certain rights and protections under applicable portions of the Employee Retirement Income Security Act of 1974 (ERISA) and/or the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These rights and protections may include the following:

*Your* right to examine, without charge, at your plan administrator's office and at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the plan with the Department of Labor (such as detailed annual reports), and plan descriptions.

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



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

### Plan "fiduciaries"

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

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

### Enforcement of ERISA rights

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

- If *you* request materials to which *you* are entitled from the plan and do not receive them within 30 days, *you* may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay *you* up to \$110 a day until *you* receive the materials (unless the materials were not sent because of reasons beyond the control of the administrator).
- If *you* have a claim for benefits or an appeal of a coverage decision, which is denied or ignored, in whole or in part, *you* may file suit in a state or federal court.

- If plan fiduciaries misuse the plan's money or if *you* are discriminated against for asserting your rights, *you* may seek assistance from the U.S. Department of Labor, or *you* may file suit in a federal court. The court decides who pays court costs and legal fees.

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

## Assistance

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

## Changes in the health plan

Your employer may amend this health plan at any time. Any amendment to the health plan will change covered services to *covered persons* on the *effective date* of the change. This applies even though *you* may have an ongoing condition at the time of the change.

## Complaint and appeal process

In order for *your health plan* to remain responsive to your needs, *we've* established both a complaint process and an appeal process. Should *you* have a problem or question about *your health plan*, a Member Services representative will assist *you*. Most problems and questions can be handled in this manner. *You* may also file a written complaint or appeal with us. Complaints typically involve issues such as dissatisfaction about *your health plan's* services, quality of care, the choice of and accessibility to *your health plan's providers* and network adequacy. Appeals typically involve a request to reverse a previous decision made by *your health plan*. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

### Complaint process

Upon receipt, your complaint will be reviewed and investigated. *You* will receive a response within 30 calendar days of *your health plan's* receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to *you* within an additional 30 calendar days.

## 58 - Important information about your health plan

**Important:** Written complaints or any questions concerning your health insurance may be filed to the following address:

Anthem Blue Cross and Blue Shield  
Attention: Member Services  
P.O. Box 27401  
Richmond, VA 23279

### Appeal process

*Your health plan* is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions *you* find unacceptable. There are two types of appeals. Internal appeals are requests to reconsider coverage decisions of *pre-service* or *post-service claims*. Expedited appeals are made available when the application of the time period for making pre-service or post-service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain.

### How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation of why *you* feel the coverage decision was incorrect. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any comments, documents, or information that *you* feel *your health plan* should consider when reviewing your appeal. Please include with the explanation:

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

**Important:** *You* may contact Member Services with your appeal or any questions concerning your health insurance at the following:

Address:  
Anthem Blue Cross and Blue Shield  
Attention: Corporate Appeals Department  
P.O. Box 27401  
Richmond, VA 23279

Telephone:  
800- 582- 6941

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

### **How your health plan will handle your appeal**

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

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

- For pre-service claims, we will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims, we will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, we will respond orally within 1 working day after receipt, from the member or treating provider, of the request to appeal, and will then provide written confirmation of our decision to the member and treating provider within 24 hours thereafter. In no event will the notification be provided later than 72 hours after receipt of the request to appeal.

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

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

## Notice in writing

Any notice required under this health plan must be in writing. Notice given to your employer will be sent to your employer's address, stated in the group application as provided by the group. Notice given to a *covered person* will be sent, at *our* option, to the plan administrator or to your address as it appears on *our* records. *Anthem*, the plan administrator, or a *covered person* may indicate a new address for giving notice.

## Time limits on legal action

No legal action on a claim may be brought against *Anthem* or *your health plan* until after all appeal rights with respect to the claim have been exhausted. No legal action on a claim may be brought more than one year following the date that all appeal rights with respect to the claim have been exhausted. This limit applies to matters relating to this health plan, to *our* performance under this health plan, or to any statement made by an employee, officer, or director of *Anthem* concerning this health plan or the benefits available to a *covered person*.

## Limitations of damages

In the event a *covered person* or his representative sues *Anthem*, or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this health plan, the damages shall be limited to the amount of the *covered person's* claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. Under no circumstances shall this provision be construed to limit or preclude any extra contractual damages that may be available to *you* or your representative.

## Laws governing this health plan

This health plan is governed by federal laws regulating employer welfare plans.

## Anthem's continuing rights

On occasion, we may not insist on your strict performance of all terms of this health plan. This does not mean the plan gives up any future rights it has under this health plan.

## Anthem's relationship to providers

The choice of a health care *provider* is solely the *covered person's*. *Providers* are neither *Anthem* employees nor agents. We can contract with any appropriate *provider* or *facility* to provide services to *you*. *Our* inclusion or exclusion of a *provider* or a *covered facility* in any network is not an indication

of the *provider's* or *facility's* quality or skill. *We* make no guarantees about the health of any *providers*. *We* do not furnish covered services but only make payment for them when received by *covered persons*.

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

## **Assignment of payment**

A *covered person* may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not waive or otherwise restrict, Anthem's right to direct future payments to a *covered person* or any other entity. This provision does not apply to dentists and oral surgeons.

Once covered services are rendered by a provider, Anthem will not honor requests not to pay the claims submitted by the provider. Anthem will have no liability to any person because it rejects the request.

## Member Rights and Responsibilities

Successful relationships take a strong commitment from all sides – with each side recognizing the rights and responsibilities of the other. Your health care is no different. It takes strong team work between *you*, your health care professionals, and *Anthem* for coverage *you* can count on. Below is a statement of rights and responsibilities that guide our relationship with *you*. Please read through them, and should *you* have any questions, don't hesitate to give us a call.

### We are committed to:

- Recognizing and respecting *you* as a member.
- Encouraging your open discussions with your health care professionals and *providers*.
- Providing information to help *you* become an informed health care consumer.
- Providing access to health benefits and *our* network *providers*.
- Sharing *our* expectations of *you* as a member.

### You have the right to:

- Participate with your health care professionals and *providers* in making decisions about your health care.
- Receive the benefits for which *you* have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and *our* policies.
- Receive information about *our* organization and services, *our* network of health care professionals and *providers*, and your rights and responsibilities.
- Candidly discuss with your physicians and *providers* appropriate or *medically necessary* care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: *our* organization, any benefit or coverage decisions *we* (or *our* designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.

### You have the responsibility to:

- Choose a participating *primary care physician* if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if *you* have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if *you* need it.

- Understand your health problems and participate, along with your health care professionals and *providers*, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that *we* and/or your health care professionals and *providers* need in order to provide care.
- Follow the plans and instructions for care that *you* have agreed on with your health care professional and *provider*.
- Tell your health care professional and *provider* if *you* do not understand your treatment plan or what is expected of *you*.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Member Services Department know if *you* have any changes to your name, address, or family members covered under your policy.
- Provide *us* with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits *you* may have in addition to your coverage with *us*.

We are committed to providing quality benefits and customer service to *our* members. Benefits and coverage for services provided under the benefit program are governed by the Group Contract and this Member Booklet document, and not by this Member Rights and Responsibilities statement.

## Definitions

### **Activities of daily living**

means walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

### **Adverse benefit determination**

is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by the health plan.

### **Allowable charge**

means the amount on which deductible (if any), copayment, and coinsurance amounts for eligible services are calculated.

### **Coinsurance**

is the percentage of the allowable charge you pay for some covered services.

### **Copayment**

is the fixed dollar amount you pay for some covered services.

### **Covered persons**

are you and enrolled eligible dependents.

### **Deductible**

is a fixed dollar amount of covered services you pay in a calendar year before your health plan will pay for any remaining covered services during that calendar year.

### **Effective date**

is the date coverage begins for you and/or your dependents enrolled under the health plan.

### **Emergency**

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

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

### **Enrollment date**

means your first day of coverage under your employer's group health plan or, if your employer's plan imposes a waiting period for eligibility, the first day of your waiting period.

### **Experimental/investigative**

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

**Facilities are:**

- dialysis centers
- home health care agencies
- hospice providers
- hospitals
- skilled nursing facilities

**First- tier drugs**

have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi- source brand drugs.

**Full- time student**

means a dependent child attending a recognized college or university, trade or secondary school, carrying a full-time course load as defined by the institution in which the child is enrolled. Certification may be required, annually, as proof of full-time student status.

**Future Moms**

is a program designed to help women have healthy pregnancies and to help reduce the chances of a premature delivery.

**Group administrator**

is the benefits administrator at your employer.

**High dose**

means a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

**Home care services**

are services rendered in the home setting. Home care includes services such as skilled nursing visits and physical, speech, and occupational therapy for patients confined to their homes. This also means infusion services rendered in the home setting. Infusion services include such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Infusion services rendered in the home setting do not require that the patient is confined to his/her home.

**Inpatient**

means when you are a bed patient in the hospital.

**Inpatient facilities**

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

**KeyCare PPO Network**

is a network of providers and facilities that has agreed to accept Anthem's allowable charge as payment in full for their services (see page 9 for a definition of allowable charge). When you receive care from KeyCare PPO Network providers and facilities, you won't be charged for any outstanding balances beyond your deductible (if any), copayment, and/or coinsurance amount for covered services detailed in the Summary of benefits (see page 1) .

**Maintenance medications**

are those you take on a regular, recurring basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes.

**Medical equipment (durable)**

is used for a medical purpose, can withstand repeated use, and is appropriate for use in your home for activities of daily living purposes.

**Medically necessary**

to be considered medically necessary, a service must:

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

**Mental health services**

are for the diagnosis and treatment of a psychiatric condition, including nervous, mental, and emotional disorders, including alcohol and drug abuse.

**Out-of-network**

is care covered at a lower level of benefits. After *you* satisfy a calendar year *deductible*, you are responsible for your *coinsurance*.

**Outpatient**

is when you receive care in a hospital outpatient department, emergency room, professional provider's office, or your home.

**Outpatient mental health services**

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

**Partial day services**

are used as an alternative to inpatient treatment.

**Plan administrator**

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

**Post- service claims**

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

**Pre- existing condition**

is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the *enrollment date*.

**Prescription drugs**

are medicines, including insulin, that require a prescription order from your doctor.

**Pre- service claims**

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

**Providers are:**

- acupuncturists
- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric mental health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- occupational therapists
- opticians
- optometrists
- podiatrists
- registered physical therapists
- speech pathologists

**Qualified beneficiary**

is a covered person who is eligible for a temporary extension of coverage under *your health plan* because of the COBRA law.

**Qualifying event**

is an event that allows you or covered persons enrolled with you to select continuation of coverage under the COBRA law.

**Retail health clinic**

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

**Second- tier drugs**

will have a higher copayment than first-tier drugs. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic, single source, or multi-source brand drugs.

**Setting**

is the place where you receive treatment. It could be your home, your provider’s office, a hospital outpatient department, a skilled nursing home, hospital inpatient room, or a partial day program.

**Significant break in coverage**

means a period of 63 consecutive days during which *you* do not have any creditable coverage. Days in a waiting period imposed by your employer do not count toward the 63 days. If *you* sought individual insurance coverage, the days between when *you* submitted your completed application and when the individual policy was effective or denied do not count toward the 63 days.

**Skilled nursing facility**

is a facility licensed by the state in which it operates to provide medically skilled services to inpatients.

**Stay**

is the period from the admission to the date of discharge from a facility, including hospitals, hospices, and skilled nursing facilities. All facility stays, for the same or related condition, less than 90 days apart are considered the same stay, and a new inpatient copayment will not apply.

**Third- tier drugs**

will have a higher copayment than second-tier drugs. This tier will contain non-preferred or high cost medications. This tier may include generic, single source, or multi-source brand drugs.

**Urgent care claims**

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

**Visit**

a period during which a covered person meets with a provider to receive covered services.

**We, us, our, Anthem**

is Anthem Blue Cross and Blue Shield.

**You**

the enrolled employee.

**Your health plan**  
the Anthem Lumenos plan.

## Exhibit A

### Experimental/investigative criteria

Experimental/investigative means any service or supply that is judged to be experimental or investigative at *Anthem's* sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as *experimental/investigative*:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
  - a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
    - the following three standard reference compendia defined below:
      - 1) the U.S. Pharmacopoeia Dispensing Information
      - 2) the American Medical Association Drug Evaluations
      - 3) the American Hospital Formulary Service Drug Information
    - in substantially accepted peer- reviewed medical literature. Peer- reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer- reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
  - b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.
2. There must be enough information in the peer- reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research *setting*.
4. The service or supply must be as safe and effective outside a research *setting* as current diagnostic or therapeutic options.

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

## Clinical trial costs

Clinical trial cost means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

- 1) The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial;
- 2) Treatment provided by a clinical trial is approved by:
  - The National Cancer Institute (NCI);
  - An NCI cooperative group or an NCI center;
  - The U.S. Food and Drug Administration in the form of an investigational new drug application;
  - The Federal Department of Veterans Affairs; or
  - An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI;
- 3) With respect to the treatment provided by a clinical trial:
  - There is no clearly superior, non- investigational treatment alternative;
  - The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non- investigational alternative; and
  - The *covered person* and the physician or health care *provider* who provides the services to the *covered person* conclude that the *covered person's* participation in the clinical trial would be appropriate; and
- 4) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

“Patient cost” under this paragraph means the cost of a *medically necessary* health care service that is incurred as a result of the treatment being provided to the *covered person* for purposes of a clinical trial. “Patient cost” does not include (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

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## Special features and programs

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

### Your health account

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

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

If *you* have established a health account, dollars may be added to it as *you* earn rewards for participating in and/or completing certain lifestyle improvement programs. Please see **Rewards** in the section that follows for more details.

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

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

### Rewards

*You* are provided with opportunities to earn rewards by participating in and/or completing certain lifestyle improvement programs available through the 360° Health Program. Participation in the rewards program ends on the date that *you* or covered family members cease to be eligible under this health plan.

Rewards are allocations made to your health account that help to offset out-of-pocket expenses such as *deductible* or *coinsurance* amounts.

You may have to satisfy certain eligibility criteria before you can participate in these programs. The following programs are available to covered members, as specified below, at no out-of-pocket cost.

**MyHealth Assessment - an online health assessment tool with a \$50 reward opportunity**

One of the tools available to help you take the first step toward improving your health is MyHealth Assessment. By completing this online questionnaire, you and your family members can each get a snapshot of your current health status, identify potential health risks, and identify tools, resources and programs available to you to help lower your risks and achieve healthier outcomes. Previously-completed health assessments may be updated in subsequent years.

While the initial health assessment and any subsequent year updates may be completed by any and all family members, only one adult covered family member is eligible to receive the \$50 reward allowance for completing or updating the health assessment in any one year.

**Healthy Lifestyles: Tobacco-Free Program – a personalized quit program with a \$50 reward opportunity**

The Healthy Lifestyles: Tobacco-Free program helps each participant develop a personalized quit plan tailored to their unique needs, based on their current state of health and risk factors, behaviors and lifestyle, and psychological and preference factors associated with the behavior change process. The program then provides participants with the support, resources and motivation to successfully achieve their quit goal. Support is provided through individualized online and telephonic coaching and online support communities to ensure that consumers stay motivated and on track. Nicotine replacement therapy is included.

Participation is open to you and covered family members age 18 and older. You and your covered spouse are eligible to receive a \$50 reward allowance (limited to one reward per person per lifetime) for completing this program.

**Healthy Lifestyles: Healthy Weight Program – a personalized weight management plan with a \$50 reward opportunity**

The Healthy Lifestyles: Healthy Weight program helps each participant develop a personalized weight management plan tailored to their unique needs, based on their current state of health and risk factors, behaviors and lifestyle, and psychological and preference factors associated with the behavior change process. The program then provides participants with the support, resources and motivation to successfully reach their healthy weight. Support is provided through individualized online and telephonic coaching and online support communities to ensure that consumers stay motivated and on track.

Participation is open to you and covered family members age 18 and older, who have a Body Mass Index (BMI) of 25 or higher. You and your covered spouse are eligible to receive a \$50 reward allowance (limited to one reward per person per lifetime) for completing this program.

### **Health coaching programs – a suite of programs with a \$100 reward opportunity for enrolling and a \$200 reward opportunity for graduating**

Another set of tools available to help you improve your health is our suite of health coaching programs, included for a variety of health conditions and other health needs. The suite of health coaching programs includes the following programs:

- ConditionCare: for members with ongoing health conditions such as asthma, diabetes, heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD).
- MyHealth Coach: provides guidance and support for a broad spectrum of health needs, with particular focus on hypertension (high blood pressure), hyperlipidemia (high cholesterol), low back pain, cancer/oncology (breast, colon, lung, prostate, skin) and musculoskeletal/arthritis (hip replacement, knee replacement, and osteoporosis).
- ComplexCare: for consumers with conditions not already managed by ConditionCare and predicted to incur high costs in the future, with a focus on complex health needs.
- Future Moms: provides guidance and support for healthy pregnancies and deliveries, with a focus on reducing low birth weight and pre-term births.

Participants eligible for a health coaching program are identified through the information provided in the MyHealth Assessment, through claims data or through physician and other referrals. Most of the conditions managed by the health coaching programs are eligible for rewards; however, there are a few exceptions (for example: pre- and post elective surgery). All health coaching programs pair you with a specially trained registered nurse who will guide you and work with you, providing one-on-one assistance to develop a personalized plan to help you better manage your health condition.

Rewards can be earned in two ways: by enrolling in a health coaching program, and by completing or graduating from a health coaching program. You'll receive a \$100 reward allowance for enrolling in a qualified program (one reward per covered person per year). You'll receive a \$200 reward allowance for achieving your health goals and graduating from the program (one reward per covered person per year). Each Member is allowed only one enrollment reward and one graduation reward per year.

There are no limits to the number of covered family members who may enroll in and graduate from the health coaching program. Any covered family member with a health condition that requires ongoing attention is eligible to enroll. Family members with multiple health conditions will be enrolled in one, holistic health coaching program. Members who remain qualified can enroll and graduate in the health coaching programs and earn rewards in subsequent years.

### **Other tools and services**

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

## **24/7 NurseLine**

Illness or injury can happen, no matter what time of day. As an *Anthem* health plan member, *you* have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and *you* can call as often as *you* like. Call 866-800-8780.

## **MyHealth@Anthem®**

When *you* visit [anthem.com](http://anthem.com), *you* can access this personalized online resource center. It's full of interactive tools to help *you* assess, manage and improve your health.

## **AudioHealth Library**

For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, there's the AudioHealth Library. It's accessible by phone with more than 400 recorded health topics.

## **Online Preventive Guidelines**

At [anthem.com](http://anthem.com), *you* can use the online preventive guidelines to check on when *you* should have certain check-ups, immunizations, screenings and tests.

## **Anthem Healthy Solutions Newsletter**

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

## **SpecialOffers@Anthem<sup>SM</sup>**

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

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

## Vision Program

To help you care for your eyes, valuable vision discounts are available to you. In order to take advantage of the available discounts, you should seek care from a Blue View Vision participating provider.

### Your Eyewear Discounts

When you visit a Blue View Vision participating eye care professional or vision center, you'll pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non-disposable) contact lenses selected as you would like.

Your eyewear discounts/costs at participating Blue View Vision provider offices are as follows:

Service	Member Cost*
Frame	35% off retail price
<b>Standard Plastic Lenses</b>	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
<b>Lens Options</b>	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch- Resistance	\$15
Standard Polycarbonate	\$40
Standard Progressive (Add- on to bifocal)	\$65
Standard Anti- Reflective Coating	\$45
Other Add- ons and Services	20% off retail price
<b>Contact Lenses</b>	
Conventional (non- disposable) - materials only	15% off retail

\*Discounts apply towards a complete pair of eyeglasses. If eyeglass materials are purchased separately, a 20% discount is applied.

Plus, Anthem members have access to discounts on laser vision correction surgery and other vision discounts through [SpecialOffers@Anthem](mailto:SpecialOffers@Anthem).



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