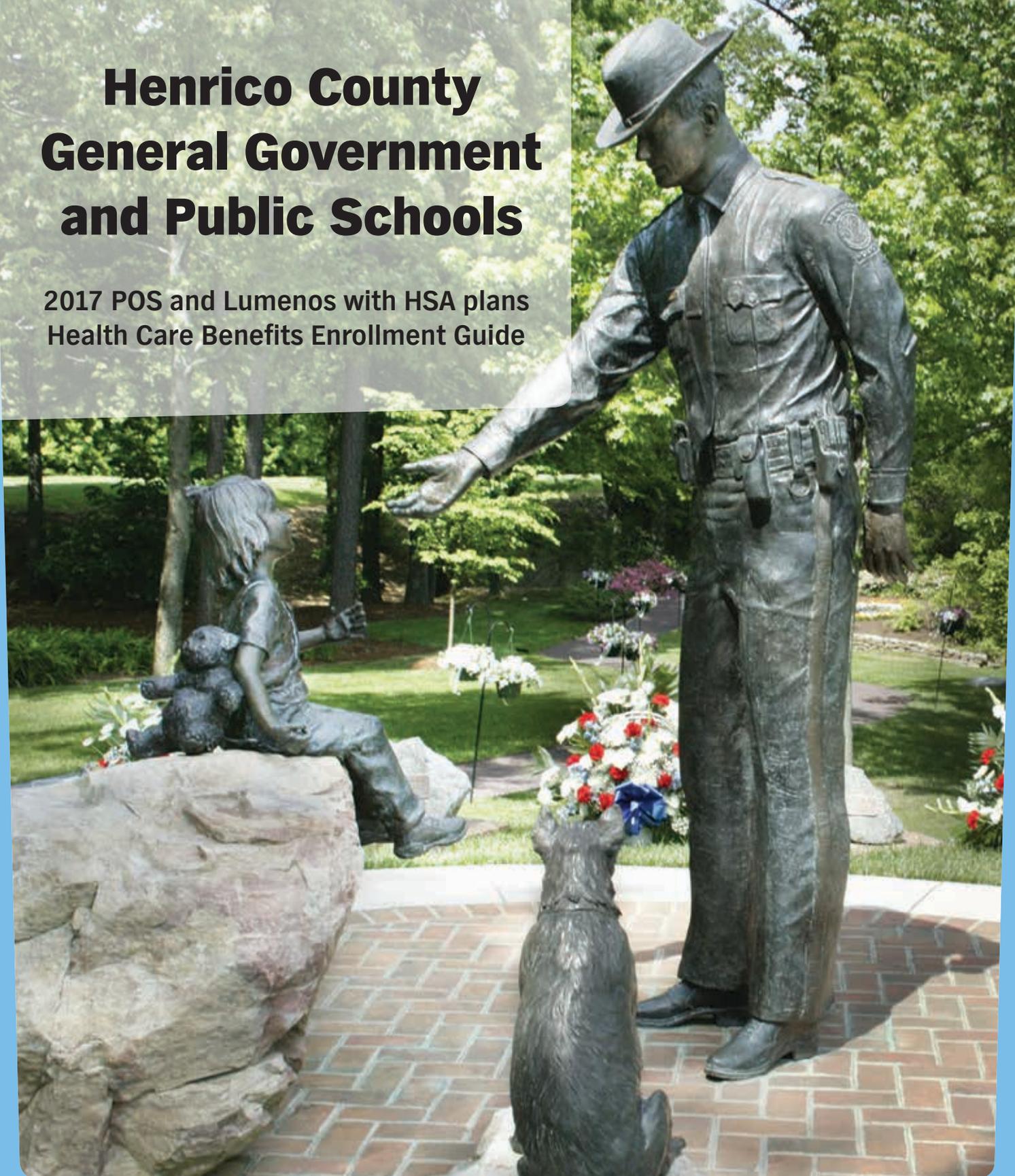


Henrico County General Government and Public Schools

2017 POS and Lumenos with HSA plans
Health Care Benefits Enrollment Guide



County of Henrico
General Government



Anthem HealthKeepers

Administered by HealthKeepers, Inc., an affiliate of Anthem Blue Cross and Blue Shield

Henrico County General Government and Public Schools Anthem HealthKeepers important contact information

Important phone numbers to keep handy

Member Services

Standard POS and Premier POS: 1-800-451-1527

Lumenos with HSA: 1-800-582-6941

Monday through Friday 8:00 a.m. to 6:00 p.m.

24/7 NurseLine

Standard POS and Premier POS: 1-800-337-4770

Lumenos with HSA: 1-866-800-8780

BlueCard Access (for information while you're traveling out of state)

1-800-810-2583

Guest Membership

1-866-823-5391

Nutritional Counseling

Call Member Services at 1-800-451-1527

Advanced Diagnostic Imaging Benefit (applies to Standard POS and Premier POS plans only)

Call Member Services at 1-800-451-1527

Mail Order Pharmacy Services

1-866-281-4279

Provider Services (in case your doctor needs to contact Anthem to coordinate a service for you or obtain an authorization)

1-800-533-1120

Pre-Authorization (for members who choose to go out-of-network)

1-800-533-1120

Mental Health Services (for services requiring pre-authorization)

1-800-991-6045

Blue View Vision

Call Member Services:

Standard POS and Premier POS: 1-800-451-1527

Lumenos HSA: 1-800-582-6941

Visit us at www.anthem.com

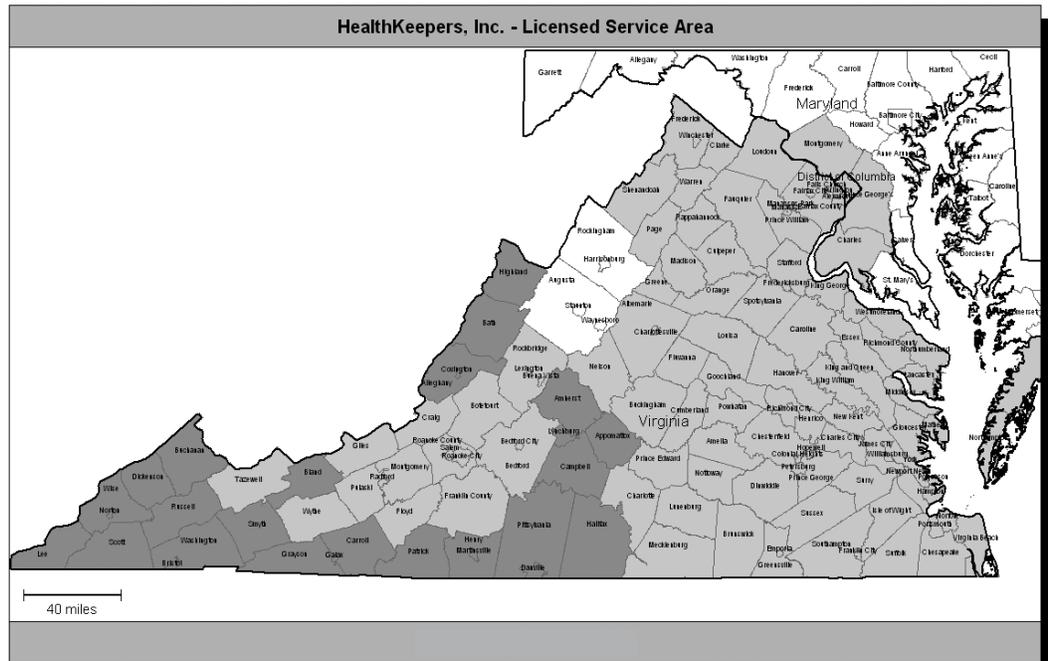
Fast facts

Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. have been serving the health care needs of Virginians for more than 75 years. We have offices throughout the state, including Richmond, Virginia Beach, Roanoke, Lynchburg and Northern Virginia.



Anthem, Inc. is an independent licensee of the Blue Cross and Blue Shield Association serving members in 14 states. With 7,000 employees in VA and more than 52,000 employees nationwide, we are able to leverage national networks and resources while still providing strong local presence and support. That's good news for the 38 million members we serve - roughly one in every nine Americans.

Our products are backed by the support of the National Committee for Quality Assurance, which has affirmed us its highest accreditation rating of "Excellent."



HealthKeepers, Inc. - Licensed Service Area
 Part of Service Area - Not For Commercial Business

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Welcome to Anthem HealthKeepers benefits

We're glad you're taking time to check out all that Anthem HealthKeepers has to offer you. We are excited for the opportunity to provide health plan coverage to Henrico County General Government and Public Schools for the upcoming year. Choosing your benefits is an important decision, and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with Anthem HealthKeepers coverage. It shows what's available to you, what you get with each benefit and how the plans work.

Explore the Anthem HealthKeepers membership advantage.

We know you're busy. That's why we've made sure it only takes a few moments to explore the advantages of being an Anthem HealthKeepers member, including:

- There's a good chance your doctor is part of Anthem HealthKeepers' network. To find out, go to www.anthem.com and search the Find a Doctor tool.
- You get more than access to coverage. You also get tools, resources and guidance that may help you reach your personal, healthy best.
- Our web site - www.anthem.com - has the answers you need. Simply go to www.anthem.com for answers to your claims questions and find detailed health benefit information.
- This booklet goes into all this - and more. Please take a few minutes to look over the information and keep this booklet. It may come in handy.

Registering on www.anthem.com is step one.

Once you get your ID card, registering is easy; all you need is your ID card, the Internet and five minutes. After you register at www.anthem.com, you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

- Go to www.anthem.com
- Enter the site by clicking on Member Log In
- Follow instructions to create your user name and password and you're ready to go!

Read on for information to help you choose your benefits with confidence. If you have any questions, your benefits manager will be happy to answer them. Thanks for considering Anthem HealthKeepers.

Your health benefits

Your member ID card

Your Member ID card is the first step in using your health care. Once we receive your information from Henrico County General Government and Public Schools, you will receive an ID card. Members will usually receive their ID cards within 10 working days after we have processed the enrollment/change.

The ID card lists the subscriber's member number, the group number, deductibles, copayments or coinsurance for certain in-network benefits and the date the benefits described on the card begin for that member. Each covered family member will receive a separate ID card.

The member number is a system-generated number. Please review the ID card to make sure the information is correct. If any information is incorrect, contact Henrico County General Government and Public Schools. If you need additional cards, you can print them at your convenience by logging in to www.anthem.com. You may also contact Member Services to request a card (see Important Phone numbers page). It is important that you present your ID card prior to receiving medical care.

 Anthem HealthKeepers Offered by HealthKeepers, Inc.		Point of Service Henrico Co. Govt. & Schools
JAMES MEMBER		
Identification Number YTS999M99999		PCP Name PCP Open Access PCP Effective Date 01/01/2017 Plan Name HealthKeepers Open Access
Group Number: 99999 BC/BS Plan Numbers: 423/823 Rx Bin Number: 003858 Rx Group: WLAA Rx PCN: A4 Product: Standard POS	PCP/Specialist: \$25/\$45 Inpatient: 30% Outpatient Surgery: 30% Emergency Room: \$150 Rx: \$10/\$30/\$55 \$150 DED	
Issue Date: 01/01/2017		 

 Anthem HealthKeepers Offered by HealthKeepers, Inc.		anthem.com Member Services: 1-800-451-1527 Provider Services: 1-800-533-1120 Authorization: 1-800-533-1120 24/7 NurseLine: 1-800-337-4770 Mental Health Services: 1-800-991-6045 Pharmacist Services: 1-800-824-0898 Mail Order Rx: 1-866-281-4279 livehealthonline.com
Members: When submitting inquiries always include your identification number from the face of the card. Possession or use of this card does not guarantee payment.		
Providers: Please submit claims to your local BCBS plan. To ensure prompt claims processing please include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of this card.		
HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.		

 Anthem HealthKeepers Offered by HealthKeepers, Inc.		Point of Service Henrico Co. Govt. & Schools
JAMES MEMBER		
Identification Number YTS999M99999		PCP Name PCP Open Access PCP Effective Date 01/01/2017 Plan Name HealthKeepers Open Access
Group Number: 99999 BC/BS Plan Numbers: 423/823 Rx Bin Number: 003858 Rx Group: WLAA Rx PCN: A4 Product: Premier POS	PCP/Specialist: \$20/\$40 Inpatient: \$200 per day up to \$1000 Outpatient Surgery: \$200 Emergency Room: \$150 Rx: \$10/\$30/\$55 \$150 DED	
Issue Date: 01/01/2017		 

 Anthem HealthKeepers Offered by HealthKeepers, Inc.		anthem.com Member Services: 1-800-451-1527 Provider Services: 1-800-533-1120 Authorization: 1-800-533-1120 24/7 NurseLine: 1-800-337-4770 Mental Health Services: 1-800-991-6045 Pharmacist Services: 1-800-824-0898 Mail Order Rx: 1-866-281-4279 livehealthonline.com
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HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.		

 Anthem HealthKeepers Offered by HealthKeepers, Inc.		Point of Service / Open Access
JAMES MEMBER		
Identification Number YTT999M99999		PCP: PCP OPEN ACCESS
Group No: V00000000 BIN: 003858 PCN: A4 Rx Group: WLAA Plan Code: 426 Effective Date: 01-01-2017	LUMENOS HSA,\$3000 DED/0% RX,\$10/30/55	
Issue Date: 01/01/2017		BLUE VIEW VISION™  

 Anthem HealthKeepers Offered by HealthKeepers, Inc.		anthem.com Member Services: 1-800-582-6941 While Traveling: 1-800-810-2583 Authorization: 1-800-533-1120 24/7 NurseLine: 1-800-382-8625 Mental Hlth Svcs: 1-800-991-6045 Pharmacist Svcs: 1-800-824-0898 Mail Order Rx: 1-866-281-4279
Members: When submitting inquiries always include your identification number from the face of the card. Possession or use of this card does not guarantee payment.		
Providers: Please submit claims to your local BCBS plan. To ensure prompt claims processing please include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of this card.		
HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.		
FG8 PRINTED: 01-15-2013		

Take care of yourself

Remember to get preventive care

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

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

Preventive versus diagnostic care

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

Sometimes routine screenings reveal abnormalities or problems that require immediate intervention or additional diagnosis. When this happens, the additional necessary procedures are considered diagnostic and/or surgical, and may be covered at a different level under your medical benefit. This could affect your member cost share.

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

Here's an overview of the types of preventive services we cover. See your benefits summary to learn more.

Child preventive care (birth through 18 years, unless otherwise noted)

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

Preventive physical exams

Screening test (depending on your age) may include

- Behavioral screening and counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Fluoride supplements for children from birth through 6 years old⁶
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Iron supplements for children 0-12 months⁶
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit

- Screening and counseling for sexually transmitted infections
- Vision screening² when done as part of a preventive care visit

Immunizations

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

Take care of yourself

Remember to get preventive care

Adult preventive care (19 years and older, unless otherwise noted)

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

Preventive physical exams

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

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- Breastfeeding support, supplies and counseling (female)^{3,4}
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Contraceptive (birth control) counseling, FDA-approved contraceptive medical services provided by a doctor, including sterilization (female), and FDA-approved prescribed or women's over-the-counter contraceptives^{4,5}
- Depression screening
- Type 2 diabetes screening
- Eye chart test for vision²
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- HPV screening (female)⁴
- Intervention services (includes counseling and education):
 - Behavioral counseling to promote a healthy diet
 - Counseling related to aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79⁶
 - Counseling related to genetic testing for women with a family history of ovarian or breast cancer, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met
 - Counseling related to chemoprevention for women with a high risk of breast cancer
 - Folic acid for women 55 years old or younger⁶
 - Primary care intervention to promote breastfeeding^{3,4}
 - Screening and behavioral counseling related to alcohol misuse
 - Screening and behavioral counseling related to tobacco use including tobacco cessation products⁷

- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for obesity
- Vitamin D for women over 65⁶

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

Immunizations

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

This sheet is not a contract or policy with Anthem. If there is any difference between this sheet and the Plan Document for County of Henrico Health Plan (Plan Document), the Plan Document will govern. Please see the Plan Document for Exclusions and Limitations.

- 1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost-share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Plan Document or call the Customer Care number on your ID card.
- 2 Additional vision services are available through Blue View Vision. Refer to the Blue View Vision section on page 55 for more information.
- 3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.
- 4 This benefit also applies to those younger than 19.
- 5 To get 100% coverage for birth control, you must present a prescription at an in-network pharmacy for a generic drug, a brand-name drug that doesn't have a generic equivalent, or an OTC item like female condoms or spermicide. A cost-share may apply for other prescription contraceptives, based on your drug benefits.
- 6 To get 100% coverage, you will need to present a prescription from a doctor or other health care provider at an in-network pharmacy.
- 7 For those 18 years and older, 100% coverage of tobacco cessation products requires a prescription from a doctor that must be presented at an in-network pharmacy. Coverage is provided for select generic products, brand-name products with no generic alternatives, and FDA-approved over-the-counter products.

Vaccines are important

Vaccines are important. They not only prevent disease in those who get the vaccine, they also help protect against unvaccinated people. Vaccines save lives and money.

In the United States, vaccinations and modern medicine have wiped out or contained many serious infectious diseases, such as polio, measles, mumps, rubella, diphtheria, whooping cough, and tetanus.

Anthem's Prescription Program covers the drugs listed below with a prescription from your doctor. Call any participating pharmacy to make sure a certified immunizing pharmacist is on duty and your vaccine is in stock. Visit www.anthem.com for a list of participating pharmacies.

- Hepatitis A - Havrix, Vaqta, Twinrix
- Hepatitis B - Engerix, Recombivax HB, Twinrix
- HPV - Gardasil
- Meningitis - Menomune, Menactra
- Tetanus - Tetanus Toxoid
- Diphtheria/Tetanus - Diphtheria/Tetanus Toxoid
- Measles - Attenuvas
- Mumps - Mumpsvax
- Rubella - Meruvax II
- Chicken Pox - Varivax
- Shingles/Zoster - Zostavax
- Pneumococcal - Pneumovax
- Influenza - Fluzone, Fluvirin, others

Some immunizations are available, based upon age-appropriate guidelines. Flu shots for 2017:

- A single shot protects against Influenza.
- Flumist and Fluzone HD are excluded from coverage.
- \$0 copay at pharmacies that participate in the Anthem Health Care/Vaccine Program.
- For the Standard POS and Premier POS plans, you pay a PCP copayment if the shot is given at a PCP office and if other services are received.
- For the Lumenos with HSA plan, your deductible will apply first if the shot is given at your PCP office and if other services are received.

Call Member Services if you have questions.

Nutritional counseling

Interested in Living a Healthier Lifestyle? Your coverage includes access to nutritional counseling.

What can nutritional counseling do for you?

- Registered Dietitians (RDs) are experts in the science of nutrition and can provide advice on developing an appropriate daily meal plan designed around your specific health needs.
- An RD can work with your PCP to help coordinate your overall health and nutrition goals.
- An RD can help you understand food advertising, how to read food labels, and determine food fact from fiction.
- Nutritional counseling can take the guess work out of “healthy” eating.

How the benefit works

Any member enrolled in the Henrico County General Government and Public Schools health plan may access this benefit. The health plan pays the first \$45 of the cost of a visit, up to five visits per year. You must select a RD who has agreed to deliver services to our members. RDs on this list have agreed to file the claim with Anthem.

Learn more

For the list of “Registered Dietitians,” or if you have any questions, contact Member Services.

Please note, this benefit is only available if you’re enrolled in the Standard POS or Premier POS plan.

Advanced Diagnostic Imaging Services

Imaging services such as CT scans and MRIs help your doctor see what's going on inside your body. Imaging services like these can cost as much as \$3,000, and the cost can vary by hundreds, even thousands of dollars depending on where you go for these services. This is because different places charge different prices for their imaging services. But a higher price doesn't mean higher quality. There are several in-network doctors who provide quality imaging services (typically MRIs, MRA, CTA and CT Scans) in their offices. That is why your benefit encourages you to go to providers who have these services available in their offices – your cost will be lower when you use these providers.

Remember that these services need to be pre-authorized through Anthem (except when these advanced imaging tests are done in conjunction with an emergency room visit). The doctor requesting the test calls Anthem to obtain approval. Once approved, your doctor's office usually tells you where to have the test done. If it's at an outpatient department of a hospital or a free-standing imaging facility, your cost will be higher. So keep this in mind should you need one of these tests.

It's your choice – here's how the benefits will work and your cost for each setting:

Imaging Services	Standard POS	Premier POS
Office Setting	10% after deductible	\$50 copay after deductible
Any other setting (free-standing or outpatient department of a hospital)	30% after deductible	\$200 copay after deductible

You can view some cost and quality data on your own by logging onto the www.anthem.com/Member Log In. Once you're logged in, click on the "Estimate Your Cost" tool. There you can compare costs for imaging as well as other outpatient and inpatient services.

For the list of providers who have imaging services available in their offices, contact Member Services.

Find a doctor online

We believe that finding a doctor online is one of the top reasons many of you visit our website. That's why we keep working on our Find a Doctor tool to make it better. Here's how you can get information about doctors in your area.

For members

1. Visit anthem.com and log in.
2. Select the **Find a Doctor** tool on the right side of the page.
3. Select the type of doctor you're looking for.
4. Select **Search**.

For non-members

1. Go to anthem.com to find a listing of available providers.
2. Select **Menu** and then choose **Find a doctor**.
3. Answer a few questions, so we can help find you the right plan and doctor in your plan.
4. Enter or select the plan/network.*
5. Select a type of provider, place or name.
6. Select **Search**.

*For your plans, pick "Anthem HealthKeepers (HMO)".

To search for doctors, hospitals, pharmacies and more from your mobile device, go to www.anthem.com. Or, download our free app from the App Store on your Apple or Android mobile device. Search Anthem Blue Cross and Blue Shield and download.

To search for an out-of-state provider, scroll down the Medical Plan Employer-sponsored options until you see "National PPO/BlueCard PPO." This will bring you the largest list of providers. Please note: care rendered out-of-state will be subject to out-of-network benefits unless the service is for emergency care.

Emergency and urgent care

Our plans provide coverage for medical emergencies, no matter where they occur. But it is important for you to understand the difference between an emergency and an urgent situation.

If you are experiencing a medical emergency, get the care you need. It would be best to go to the nearest participating hospital emergency room (ER). Hospital ERs that do not participate with us should only be used if the delay in receiving care from a participating ER could reasonably be expected to cause your condition to get worse.

If you are admitted to a non-participating hospital in an emergency, you must let us know within 48 hours or by the next working day if the 48-hour deadline falls on a weekend or legal holiday. An exception to this requirement is made if you are incapacitated and unable to contact us. In this case, you must make arrangements to notify us as soon as possible.

What is a medical emergency?

A medical emergency is the sudden onset of a medical condition, such as unusually severe symptoms. You should seek immediate medical attention if the condition could result in serious jeopardy to your mental or physical health, serious impairment of your bodily functions, serious dysfunction of any of your bodily organs, or if pregnant, serious jeopardy to the health of the baby.

When to call your PCP before seeking care

If an emergency occurs and time permits, or if you are not sure you are experiencing a medical emergency, call your PCP, even if you are on vacation. Your PCP's office may have a doctor "on call" 24 hours a day, seven days a week.

Where to go for care

If you have an unexpected illness or injury while in the service area that requires immediate treatment, call your PCP. Your PCP may be able to see you in the office or suggest temporary measures to take before an office visit. If this is not possible, your PCP may advise you to visit one of our participating urgent care centers.

Convenient care for members

Members can use a Patient First physician as their PCP. For the Standard POS and the Premier POS plans, you will pay the PCP copayment when you receive care from a Patient First physician or any participating ER Alternative center. For the Lumenos HSA plan, your deductible will apply first, but ER Alternative centers are less costly options. This gives you greater flexibility to access primary care services in the Richmond area. To find a listing, visit www.anthem.com/eralt/va.

When out of the service area

If you have an unexpected illness not usually associated with urgent care while you are out of the service area, we may pay for treatment at an urgent care facility. For urgent care outside the service area, call the number on your member ID card.

Emergency and urgent care

Medical Emergency Examples

Some examples of a medical emergency include, but are not limited to:

Severe or unusual bleeding	Convulsions or seizures
Trouble breathing	Broken bone
Chest pain	Fainting or unconsciousness
Choking	Any vaginal bleeding in pregnancy
Suspected poisoning	

What is not a medical emergency?

As a single symptom, these are not emergencies. Call your PCP for these problems:

Coughing	Vomiting
Diarrhea	Earache
Sore throat	Toothache
Colds	Pink eye
Stomach ache	Mild fever
Rashes	Bruises

Note: your claim may be denied if you go to the emergency room when it is not a true emergency.

Urgent care examples

When a minor illness or injury occurs unexpectedly and your doctor's office is closed, consider using an urgent care center. Some examples of urgent care are:

- Sprains
- Non-severe bleeding
- Simple cuts that require stitches

24/7 Nurseline

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

Can the problem be treated at home?

Do you need to see your doctor?

Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach the 24/7 Nurseline, call the number on your ID card.

Emergency and urgent care

Comparison of emergency and urgent care			
Type of service	Standard POS Open Access	Premier POS Open Access	Lumenos HSA Open Access
Medical emergencies at a hospital Emergency Room	\$150 for each visit	\$150 for each visit	Subject to deductible. Once deductible is met, covered at 100%
Urgent care at a participating Primary Care Clinic (Patient First, PCP)	\$25 for each visit to a PCP; \$45 for each visit to a specialist	\$20 for each visit to a PCP; \$40 for each visit to a specialist	Subject to deductible. Once deductible is met, covered at 100%
Urgent care outside our service area	\$25 for each visit to a PCP; \$45 for each visit to a specialist	\$20 for each visit to a PCP; \$40 for each visit to a specialist	Subject to deductible. Once deductible is met, covered at 100%
Patient First visits will always be considered the equivalent of seeing a PCP.			
For a complete list of available urgent care centers, visit www.anthem.com/eralt/va.			
For the Standard POS and Premier POS plans: If you receive emergency services at an out-of-network emergency room, the emergency room facility charge will be covered at the in-network copay. The provider charge will be included in the in-network copay if services were received from a Blue Cross/Blue Shield participating provider; if not, you could be balance billed for the provider services.			

Guest Memberships (for members temporarily outside of the service area)

When you or any of your covered dependents will be staying temporarily outside of Virginia for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated HMO in that area. An example of when this service may be utilized is when a dependent student attends a school outside of the service area. Call a Member Services representative at 866-823-5391 to make sure that the area in which you or your dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated HMO Plans.

If the area is within the network, once you receive your Anthem HealthKeepers identification card you will need to complete the online guest membership application (https://www.anthem.com/forms/east/va_guest_membership.html) and you will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield HMO affiliate where you or your covered dependents will be staying. Member Services will explain any limitations or restrictions to this benefit. If you are staying in an area that is not within the Guest Membership Network, this service will not be available.

Please note: There are sixteen states, in addition to Puerto Rico, that do not participate in this program: Alabama, Alaska, Idaho, Iowa, Kansas, Mississippi, Montana, Nebraska, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia and Wyoming.

Coverage while traveling

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

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at www.anthem.com or call the Member Services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. Call Anthem HealthKeepers Member Services to verify your coverage.
3. Show your ID card at the time of service.
4. You are covered for office visits and other services at the same cost as out-of-network visits when you are at home.

You pay the same with any Blue Cross and Blue Shield provider as you would an Anthem HealthKeepers network provider. Plus the provider will file your claims for you. Anthem HealthKeepers will still mail your explanation of benefits, so you can double-check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 48 hours or as soon as reasonably possible.

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

Make the most of your benefits with these smart tips

Action Step #1: Ask about other facilities that can perform certain procedures

Since hospitals have higher overhead costs, their rates are usually higher for inpatient and outpatient services. If you can have your service or procedure done at a doctor's office, or surgery center, instead, you might have lower out-of-pocket costs.

Action Step #2: Ask about your options for radiology services

Your costs will be lower if you get an advanced diagnostic imaging service (MRI, MRA, CTA and CT Scans) in an office setting. See page 11 for more information. The cost for radiology services can vary depending on where they're done. So, if it's not an emergency, be sure to check with your doctor about your radiology options.

Action Step #3: Comparison shop with the Estimate Your Cost tool

Know how much a procedure will cost before having it done. With the Estimate Your Cost tool, you get side-by-side cost estimates at area facilities for more than 400 procedures, such as knee replacement, maternity services and tonsillectomy. Check out our demo at www.anthem.com. If you have the Premier POS or the Standard POS plan, it's even more important to understand upfront how much services cost because you'll pay a higher portion of the cost when using out-of-network providers. If you have the Lumenos HSA plan, it's very important to understand the upfront costs since you're responsible for the deductible first. Go to www.anthem.com, Member Log In and click on Estimate Your Costs.

Small things add up.

Some people just know how to get the absolute most from their benefits. They're experts at finding extra dollars in the corners and corridors of the health care system. They're also skilled at using plan features to their advantage. You too can be one of these in-the-know experts. Here are their secrets.

Action Step #4: Avoid using emergency rooms for conditions that aren't life-threatening

Services cost a lot more in the ER than they would in your primary care or family doctor's office. For minor stuff like minor cuts and sprains, ear infections, urinary tract infections and bronchitis, you would save money by avoiding the ER altogether. If it's not life-threatening, consider making an appointment instead. You may also save time; waiting in the ER takes longer than waiting in your doctor's lobby. See page 13 for more information about ER alternatives.

Talk to a doctor today, tonight, anytime — 365 days a year. LiveHealth Online uses two-way video chat to connect you with doctors over the Internet. You don't need to schedule an appointment, drive to the doctor's office and wait for your appointment. You don't even have to leave your home or office. Doctors can answer your questions, make a diagnosis and even prescribe basic medications. Go to LiveHealthOnline.com and set up your personal account.

Action Step #5: Get your prescriptions from a new source

You can buy your prescription drugs from a variety of places: traditional pharmacies, retailers, grocery stores and mail-order. Depending on the option you choose, you may find that prices of your prescriptions vary quite a bit from place to place. Note: if your actual prescription costs less than the copayment, you'll pay the lower amount.

Make the most of your benefits with these smart tips (continued)

Action Step #6: Choose generic over brand-name

Many generic prescription drugs can do the job just as well as higher-priced brand-names. Generics are approved by the Food and Drug Administration and cost 30-80% less. Your doctor will know whether any are available and appropriate for your treatment or condition. If there aren't, your doctor may still know of lower-cost brand-name alternatives that would also work.

Action Step #7: Use over-the-counter meds for minor conditions

Why fill an expensive prescription when a cheaper over-the-counter medication – with the same active ingredients – is available? Over-the-counter meds can be a smart choice for seasonal allergies, heartburn and other common minor conditions. Of course, before replacing a prescription with an over-the-counter med, check with your doctor.

Action Step #8: Look into our special pharmacy programs

Our Half Tablet and GenericSelect programs can help reduce your copayment by offering you simple ways to save on your medication costs. With the Half Tablet Program you order the medicine you take once a day at a higher strength and then use a tablet splitter to cut the tablets in half. Because you're ordering half the number of tablets, you can save up to 50% on your usual copayment. If you're currently taking a brand-name medicine, you may want to try the GenericSelect program. GenericSelect lets you try a generic medication on our list at no cost the first time you fill a new prescription. And, since generics cost less than brand-name drugs, you save money every time you refill the prescription for the generic after your first fill. Talk to your doctor to see if either program is right for you. For more information call the Member Services number on your ID card.

Action Step #9: Take advantage of those preventive benefits

Immunizations, mammograms and annual checkups help you stay healthy. That's why preventive services like these are covered by your plan. Don't forget to use them. They can help prevent costly chronic conditions such as diabetes and high blood pressure, which mean more services, more doctor visits, and more money out of your pocket. Your entire collection of wellness benefits can be found at www.anthem.com, or by calling the Member Services number on your ID card.

Register today at www.anthem.com

From your computer:

- Go to www.anthem.com and select Register Now
- Create a username and password
- Set your email preferences
- Select Submit

From your mobile device:

- Download the free Anthem mobile app and select Register Now
- Confirm your identity
- Create a username and password
- Set your email preferences
- Confirm and select Register

Make the most of your benefits with these smart tips (continued)

Action Step #10: Keep an eye on your EOB

You'll get an Explanation of Benefits (EOB) whenever you use your benefits and you owe a cost share. It's like your personal claim and coverage report. When you get one, make sure it's accurate and that it includes only the services you received. If you're ever not sure about a charge, call Member Services and we can help clear things up.

Action Step #11: Surround yourself with support from Anthem's Health and Wellness programs

Anthem has a collection of support and wellness programs that surrounds you with the help you need to live healthier, feel better and save money. Personalized information, 24/7 access to a nurse, and trained health management professionals – it's all ready to help you navigate the health care system and use your benefits wisely. And it's part of your plan at no extra cost.

Start by taking a MyHealth Assessment at www.anthem.com, which can analyze the choices you make and provide suggestions for the steps you can take.

Action Step #12: Use in-network doctors and hospitals

They'll cost less than out-of-network doctors. Anthem contracts with doctors and hospitals to offer services for our members at a discounted rate. These "in-network" doctors agree to accept this discounted rate as payment in full and can't balance-bill you. Doctors who aren't contracted with Anthem are considered "out-of-network." If you visit an out-of-network doctor, your out-of-pocket costs may be higher because the discount won't apply and they can balance-bill you for the difference. Don't assume that all doctors and hospitals are in our network. Before seeking services, check our Find a Doctor tool at www.anthem.com; if they're not on Find a Doctor, most likely they're out-of-network. You can also call your doctor or the Member Services number on your ID card.

Action Step #13: Get health tips from www.anthem.com

At www.anthem.com, you'll find plenty of expert information to help you stay on top of your health care options, costs and ways to improve your health. Take a few moments, explore the website and learn more. You can also call Member Services for more help.

Anthem HealthKeepers Point of Service (POS) Open Access plan

(for the Anthem HealthKeepers Standard POS and Premier POS plans)

Anthem HealthKeepers Standard POS and Premier POS are Point of Service plans, which means you're free to choose doctors in or out-of-network. These plans include an Open Access feature which allows you to seek specialist services without referrals. Of course, in-network care will usually cost less than out-of-network care. The Anthem HealthKeepers network includes many doctors and hospitals across Virginia, so you'll find plenty of choices. The point is, the choice is yours.

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

Anthem HealthKeepers POS Open Access at a glance

- **PRIMARY CARE PHYSICIANS (PCPs):** A PCP can provide preventive care and can help you make decisions about your health. Having an established PCP relationship can make it easier to handle health issues as they come up since they'll already know your history and can possibly help direct you on getting the right type of specialist care. However, you are not required to be assigned a PCP under this plan.
- **REFERRALS:** Not needed.
- **CLAIM FORMS:** No claim forms to submit when using network providers.
- **OUT-OF-NETWORK BENEFITS:** Available for most services, but at more cost than when using in-network providers. We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage. If you see an out-of-network provider, you are responsible for filing your claims. Also, Anthem pays the negotiated rates we use for our network doctors, so you will be balance billed for the difference.
- **OUT-OF-POCKET:** This is the amount you'll pay, whether it is a straight copayment or some percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

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

Anthem HealthKeepers Point of Service (POS) Open Access plan (continued)

(for the Anthem HealthKeepers Standard POS and Premier POS plans)

You're covered whenever you travel

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

You're getting more than a health plan

You get programs to actually help you manage your health. Wellness tools, health management programs and SpecialOffers@Anthem are all available through www.anthem.com. The programs are explained in detail later in this booklet. This is a brief overview of your plan's features. Your benefits summary contains the details.

Lumenos with Health Savings Account (HSA)

Using your Lumenos Plan with HSA

The Lumenos with HSA plan combines a high-deductible health plan with a health savings account (HSA). Your employer provides funds for your HSA and you may contribute through pre-tax payroll contributions or post-tax contributions. You can use the money in your HSA to pay for medical care and prescriptions that go toward satisfying your annual deductible. Once you've satisfied this deductible, the plan pays 100% of your medical services when you see Network providers. After your annual deductible, you'll have a copayment for prescription drugs depending on what tier the drug is on. If you've met your annual out-of-pocket maximum, the plan will pay 100% of the cost of all of your covered services, up to the allowed amount for the remainder of the calendar year.

All of this makes your Lumenos with HSA plan different from a conventional plan. But, getting access to care and filling a prescription is easier than you may think. Here's what to expect.

Show your ID card

After you've enrolled, you'll receive your Anthem ID card. Just present this ID card when you visit your provider.

Schedule a preventive care appointment

If you're receiving covered preventive care services, don't forget to tell your doctor that your plan covers up to 100% of the service — as long as you receive care from a network provider. (See your Plan Summary for details.)

Visit any licensed doctor or hospital

With the Lumenos with HSA plan, you can visit any licensed doctor, hospital or medical provider you want. However, the method of payment and the cost of the service may vary, depending on whether the doctor is in Anthem's HealthKeepers network or not.

Network providers:

If your provider participates in Anthem's HealthKeepers network, the office staff will usually take care of most of the work. Typically, you won't pay at the time you receive service. Instead, the office staff will photocopy your ID card and file the claim for you. It is important to allow them to file the claim on your behalf before you pay so you benefit from the network discounts.

- **After your claim is processed, Anthem will send you and your provider a Claim Recap which shows the total cost of the service, the "allowable charge" (the provider's contracted rate) and the amount you are responsible for paying.**
- **Your provider will send you a bill for any charges you are responsible to pay.**
- **If you have enough funds in your HSA, you can use your HSA debit card or check to pay the bill. If you do not have adequate funds in your HSA or you choose not to use your HSA, you will need to pay out of your own pocket.**
- **The amount you pay on covered services will go toward your deductible and out-of-pocket maximum.**

Lumenos with Health Savings Account (HSA) (continued)

Out-of-network providers:

If you see a provider who isn't in the network, you will have to pay for your service at the time of your appointment. Keep in mind: You will be responsible for the total cost of service when using an out-of-network provider. If you have money available in your account, you can use your HSA debit card or check to pay for the service or you may pay out of pocket. Your provider may file the claim for you. Or, you may have to file the claim yourself to help ensure your covered expenses are applied to your plan's annual deductible and out-of-pocket maximum. You can get a claim form at www.anthem.com.

How the Lumenos with HSA plan works for prescriptions

Getting a prescription is easy with the Lumenos with HSA plan — especially when you consider that you have access to a large network of participating pharmacies to choose from. Here's what you'll do.

Visit your local pharmacy

Your Anthem ID card is also your prescription card. Simply present your ID card when you visit your pharmacy to help ensure you receive the right discount for your prescription. Remember, you'll get better discounts when you use a network pharmacy.

The way you pay for your prescription depends on the following:

- **If you have funds in your HSA to cover the cost of your prescription, you can use your HSA debit card or check to pay for the prescription at the pharmacy. The full discounted cost of the prescription will automatically be deducted from your account and will apply toward your annual deductible. Medical and prescription deductibles are not separate!**
- **If you don't want to tap into your HSA, you can pay directly from your wallet. The cost of the prescription will still be applied toward your annual deductible.**
- **Once you have met your deductible, you'll pay only the appropriate copayment at the pharmacy, up to your plan's annual out-of-pocket maximum. If you have met your annual out-of-pocket maximum, the plan will pay 100% of the cost of your covered medications. (See your Plan Summary for details.)**

Use our mail order pharmacy and save

You can also order your prescriptions through our mail order pharmacy. This is easy and convenient because it saves you a trip to a retail pharmacy. Plus, you'll pay the amount the mail order pharmacy charges for the drug, which may be less than what you'd pay at a retail pharmacy. The way you pay works the same. You'll just provide your HSA debit card number when you submit your mail service form. If you don't have enough funds in your HSA to cover the prescription, we'll ask you for a credit card number, and your card will be charged.

Stretch your health care dollars with generics

Want to save money, so you can get even more from your HSA funds? Many times, you'll have the choice between a name brand drug and its generic equivalent. Generics are just as safe and effective as brand-name drugs, but they cost less! The next time the provider prescribes a medication, ask about generic alternatives and if they could work for you.



Henrico County General Government and Public Schools

Anthem HealthKeepers

Benefit Comparison: January 1, 2017 - December 31, 2017

	Standard POS	Premier POS	Lumenos with HSA
IN NETWORK BENEFITS			
Deductible (Individual/Family)	\$150 / \$150	\$150 / \$150	\$3,000/\$6,000 (combined with out of network)
Out-of-Pocket Maximum	\$3,000 / \$6,000	\$3,000 / \$6,000	\$4,000 / \$8,000
Inpatient Benefits	You Pay	You Pay	You Pay
Hospital	30% after deductible	\$200 per day (not to exceed \$1,000 per admission) after deductible	0% after deductible
Physician Charges	30% after deductible	No charge	0% after deductible
Maternity (Facility charges for delivery)	30% after deductible	\$200 per day (not to exceed \$1,000 per admission) after deductible	0% after deductible
Mental Health and Substance Abuse (Facility charges)	30% after deductible	\$200 per day (not to exceed \$1,000 per admission) after deductible	0% after deductible
Outpatient Benefits	You Pay	You Pay	You Pay
Referrals to Specialist Required	No	No	No
Preventive Care	No charge	No charge	No charge
Primary Care Physician (PCP) or OB/ GYN Office Visit	\$25	\$20	0% after deductible
Specialist Office Visit	\$45	\$40	0% after deductible
Urgent Care Center	\$25 PCP / \$45 Specialist	\$20 PCP / \$40 Specialist	0% after deductible
Allergy Testing	\$25 PCP / \$45 Specialist	\$20 PCP / \$40 Specialist	0% after deductible
Allergy Serum and Injections	\$25 PCP / \$45 Specialist	\$10	0% after deductible
Mammogram	No charge	No charge	No charge
Labs, Diagnostic X-rays	No charge	No charge	0% after deductible
Advanced Diagnostic Imaging-in Office setting	10% after deductible	\$50 copay after deductible	0% after deductible
Advanced Diagnostic Imaging-All other settings	30% after deductible	\$200 after deductible	0% after deductible
Maternity Outpatient Services			
Initial office visit to confirm diagnosis	\$25	\$20	0% after deductible
Pre- and post-natal care and delivery	\$50 per pregnancy	\$50 per pregnancy	0% after deductible
Maternity ultrasounds	No charge	No charge	0% after deductible
Emergency Room (waived if admitted to the hospital)	\$150	\$150	0% after deductible

	Standard POS	Premier POS	Lumenos with HSA
	You Pay	You Pay	You Pay
Outpatient Surgery Facility Professional Provider	30% after deductible 30% after deductible	\$200 after deductible No charge	0% after deductible
Outpatient Therapy: occupational, speech and physical	\$45	\$25	0% after deductible
Spinal Manipulation (30 visit limit per CY)	\$25	\$25	0% after deductible
Outpatient Mental Health and Substance Abuse	\$25	\$20	0% after deductible
Durable Medical Equipment	No charge after deductible	No charge after deductible	0% after deductible
Home Health Care (90 visit limit per CY)	\$45 per visit after deductible	No charge after deductible	0% after deductible
Skilled Nursing Facility (100 days per admission)	30% after deductible	No charge after deductible	0% after deductible
Hospice Care	30% after deductible	No charge after deductible	0% after deductible
Prescription Drugs	Mandatory Generic	Mandatory Generic	Mandatory Generic
Rx Deductible (<i>individual/family</i>)	\$150/\$150	\$150/\$150	Plan deductible applies
Retail Pharmacy (<i>30 day supply</i>)	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55	After deductible: \$10/\$30/\$55
Mail Order (<i>90 day supply</i>)	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165	After deductible: \$10/\$60/\$165
Retail 90 (<i>90 day supply purchased at a participating retail pharmacy</i>)	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165	After deductible: \$30/\$90/\$165
Routine Vision - Blue View Vision			
Annual Routine Eye Exam	\$15	\$15	\$15 (deductible does not apply)
OUT-OF-NETWORK BENEFITS			
Deductible (Individual/Family)	\$400/\$800	\$400/\$800	\$3,000/\$6,000 (combined with in-network)
Coinsurance	30%	30%	30%
Out-of-Pocket Maximum	\$3,000/\$6,000	\$3,000/\$6,000	\$6,000/\$12,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Your Benefits



Anthem HealthKeepers

Henrico County General Government and Public Schools Anthem HealthKeepers/Standard POS Plan/Open Access

Covered Services (not subject to deductible)	IN-NETWORK You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which may result in a member cost share.	*No Charge
Doctor Visits	
<ul style="list-style-type: none"> o office visits o voluntary family planning o wisdom teeth extractions (bony impacted only) o in-office surgery o allergy testing 	<p>\$25 for each visit to your PCP or OB/GYN \$45 for each visit to a specialist</p>
o urgent care visits	\$25 for each visit to your PCP \$45 for each visit to a specialist
o mammograms	No Charge
o mental health and substance abuse visits	\$25 for each visit
o allergy serum and allergy injections (if actual cost of serum and injection is less than the copay, member is only charged actual cost)	\$25 for each visit to your PCP \$45 for each visit to a specialist
Routine Vision	
o annual routine eye exam <i>Administered by Blue View Vision</i>	\$15 for each visit
Labs, Diagnostic X-rays	
<ul style="list-style-type: none"> o diagnostic tests o diagnostic x-rays (other than advanced diagnostic imaging services) *<i>Provided through LabCorp</i> o lab work* 	No Charge
Maternity Services	
<ul style="list-style-type: none"> o all routine outpatient pre-and postnatal care (excluding inpatient stays) o diagnostic testing (such as ultrasound, non-stress tests and other fetal monitor procedures) 	\$50 per pregnancy No Charge
Emergency Care	
o true emergency care visits in or out of the service area <i>*Waived if admitted directly to the hospital.</i>	\$150 for each visit to an emergency room*
Early Intervention - For children from birth through age 2	
o early intervention services	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) - For children from age 2 through 10	
<ul style="list-style-type: none"> o diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care <p>* <i>Mental Health Services</i> **<i>Unlimited physical, occupational and speech therapy.</i></p>	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o ambulance travel	No Charge
o physical, occupational and speech therapy	\$45 for each visit
o spinal manipulation and manual medical therapy services (Limited to 30 visits per plan year) <i>Administered by American Specialty Group (ASG)</i>	\$25 for each visit
<ul style="list-style-type: none"> o infusion therapy o chemotherapy o radiation therapy o dialysis 	No Charge
o nutritional counseling (maximum 5 visits per year)	\$45 benefit payable

**All Other Services
(subject to deductible)**

You will pay all the costs associated with your care until you have paid \$150 per Individual/\$150 per Family in one plan year. This is known as your deductible.

Once you reach your deductible you pay:

Inpatient Stays in a Hospital or Facility

- o semi-private room
- o private room when approved in advance
- o intensive or coronary care unit
- o maternity services
- o mental health and substance abuse services
- o skilled nursing facility (100 days for each admission)
- o occupational, speech and physical therapy

30% after deductible of the amount the health care professionals in our network have agreed to accept for their services

Other Outpatient Services

- o advanced diagnostic imaging services (includes MRI, MRA, CTA and CT scans) done in an office setting

10% after deductible of the amount the health care professionals in our network have agreed to accept for their services.

- o advanced diagnostic imaging services (includes MRI, MRA, MRS, CTA, PET scans and CT scans) done in all other settings

30% after deductible of the amount the health care professionals in our network have agreed to accept for their services

- o surgery in a hospital or facility (including bony impacted wisdom teeth extractions)

30% after deductible of the amount the health care professionals in our network have agreed to accept for their services

- o hospice care

30% after deductible of the amount the health care professionals in our network have agreed to accept for their services

- o home health care (Limited to 90 visits per plan year)

\$45 per visit after deductible

- o diabetic supplies, equipment and education

Member cost shares will be dependent on the services rendered after deductible.

- o prosthetic devices

30% after deductible of the amount the health care professionals in our network have agreed to accept for their services

- o durable medical equipment
- o medical supplies

No Charge after deductible

- o cardiac rehab therapy

30% after deductible of the amount the health care professionals in our network have agreed to accept for their services

Autism Spectrum Disorder (ASD) – For children from age 2 through 10

- o applied behavioral analysis

30% of the amount the health care professionals in our network have agreed to accept for their services (after deductible, except for services related to preventive care)

Out-of-Network Services

Deductible for services received from out-of-network health care professionals

You will pay all of the costs associated with covered services until you pay \$400 per Individual/\$800 per Family in one plan year.

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

Out-of-Pocket Maximums

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

When using in-network professionals

If you are the only one covered by your plan, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).
- If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.

When using out-of-network professionals

If you are the only one covered by your plan, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).
- If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.

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

- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under this plan
- the cost associated with vision services

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum.

SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.

*Some benefits may be subject to balance billing, if provided by a non-participating provider.
For more information on balance billing, see page 43 of this enrollment guide.*

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

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

Your Benefits



Anthem HealthKeepers

Henrico County General Government and Public Schools Anthem HealthKeepers/Premier POS Plan/Open Access

Covered Services (not subject to deductible)	IN-NETWORK You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. *During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and your provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by your provider, which may result in a member cost share.	*No Charge
Doctor Visits	
<ul style="list-style-type: none"> o office visits o voluntary family planning o wisdom teeth extractions (bony impacted only) o in-office surgery o allergy testing 	\$20 for each visit to your PCP or OB/GYN \$40 for each visit to a specialist
o urgent care visits	\$20 for each visit to your PCP \$40 for each visit to a specialist
o mammograms	No Charge
o mental health and substance abuse visits	\$20 for each visit
o allergy serum and allergy injections (if actual cost of serum and injection is less than the copay, member is only charged actual cost)	\$10 for each visit
Routine Vision	
o annual routine eye exam <i>Administered by Blue View Vision</i>	\$15 for each visit
Labs, Diagnostic X-rays	
<ul style="list-style-type: none"> o diagnostic tests o diagnostic x-rays (other than advanced diagnostic imaging services) o lab work* <i>*Provided through LabCorp</i>	No Charge
Maternity Services	
<ul style="list-style-type: none"> o all routine outpatient pre-and postnatal care (excluding inpatient stays) o diagnostic testing (such as ultrasound, non-stress tests and other fetal monitor procedures) 	\$50 per pregnancy No Charge
Emergency Care	
o true emergency care visits in or out of the service area <i>*Waived if admitted directly to the hospital.</i>	\$150 for each visit to an emergency room*
Early Intervention - For children from birth through age 2	
o early intervention services	Member cost shares will be dependent on the services rendered.
Autism Spectrum Disorder (ASD) - For children from age 2 through 10	
<ul style="list-style-type: none"> o diagnosis and treatment of autism spectrum disorder including: <ul style="list-style-type: none"> o behavioral health treatment* o psychiatric care o therapeutic care** o pharmacy care o psychological care <i>* Mental Health Services</i> <i>**Unlimited physical, occupational and speech therapy.</i>	Member cost shares will be dependent on the services rendered.
Other Outpatient Services	
o ambulance travel	No Charge
<ul style="list-style-type: none"> o physical, occupational and speech therapy o spinal manipulation and manual medical therapy services (Limited to 30 visits per plan year)* <i>*Administered by American Specialty Group (ASG)</i>	\$25 for each visit
<ul style="list-style-type: none"> o infusion therapy o chemotherapy o radiation therapy o dialysis 	No Charge
o nutritional counseling (maximum 5 visits per year)	\$45 benefit payable

**All Other Services
(subject to deductible)**

You will pay all the costs associated with your care until you have paid \$150 per Individual/\$150 per Family in one plan year. This is known as your deductible.

Once you reach your deductible you pay:

Inpatient Stays in a Hospital or Facility	
<ul style="list-style-type: none"> o semi-private room o private room when approved in advance o intensive or coronary care unit o maternity services o mental health and substance abuse services o occupational, speech and physical therapy 	\$200 per day (not to exceed a maximum of \$1,000 per admission after deductible)
o skilled nursing facility (100 days for each admission)	No charge after deductible
Other Outpatient Services	
o advanced diagnostic imaging services (includes MRI, MRA, CTA and CT scans) done in an office setting	\$50 copay after deductible
o advanced diagnostic imaging services (includes MRI, MRA, CTA, PET scans and CT scans) done in all other settings	\$200 copay after deductible
o surgery in a hospital or facility (including bony impacted wisdom teeth extractions)	\$200 copay after deductible
o hospice care	No charge after deductible
o home health care (Limited to 90 visits per plan year)	No charge after deductible
o diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered after deductible.
o prosthetic devices	No charge after deductible
o durable medical equipment o medical supplies	No charge after deductible
o cardiac rehab therapy	No charge after deductible
Autism Spectrum Disorder (ASD) – For children from age 2 through 10	
o applied behavioral analysis	20% of the amount the health care professionals in our network have agreed to accept for their services (after deductible, except for services related to preventive care)

Out-of-Network Services

Deductible for services received from out-of-network health care professionals

You will pay all of the costs associated with covered services until you pay \$400 per Individual/\$800 per Family in one plan year.

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

Out-of-Pocket Maximums

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

When using in-network professionals

If you are the only one covered by your plan, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).
- If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.

When using out-of-network professionals

If you are the only one covered by your plan, you will pay \$3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is \$0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay \$3,000 (\$6,000 total).
- If three or more people are covered under your plan, together you will pay \$6,000. However, no family member will pay more than \$3,000 toward the limit.

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

- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under this plan
- the cost associated with vision services

Under the Affordable Care Act, prescription, medical and behavioral costs all count toward one combined out of pocket maximum.

SPECIALIST VISITS DO NOT REQUIRE PCP REFERRAL.

*Some benefits may be subject to balance billing, if provided by a non-participating provider.
For more information on balance billing, see page 43 of this enrollment guide.*

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

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

Henrico County General Government and Public Schools Lumenos® with HSA Plan Summary

Overview of Covered Preventive Services

Preventive Care

Anthem's Lumenos with HSA plan covers preventive services¹ recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to help prevent avoidable premature injury, illness and death.

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

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

Child Preventive Care	Adult Preventive Care
<p>Office Visits for preventive services</p> <p>Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam and Pap test for females who are age 18, or have been sexually active.</p> <p>Immunizations:</p> <ul style="list-style-type: none"> Hepatitis A Hepatitis B Diphtheria, Tetanus, Pertussis (DtaP) Varicella (chicken pox) Influenza – flu shot Pneumococcal Conjugate (pneumonia) Human Papilloma Virus (HPV) – cervical cancer H. Influenza type b Polio Measles, Mumps, Rubella (MMR) 	<p>Office Visits for preventive services</p> <p>Screening Tests for coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams and Pap test.</p> <p>Immunizations:</p> <ul style="list-style-type: none"> Hepatitis A Hepatitis B Diphtheria, Tetanus, Pertussis (DtaP) Varicella (chicken pox) Influenza – flu shot Pneumococcal Conjugate (pneumonia) Human Papilloma Virus (HPV) – cervical cancer

Summary of Exclusions or Limitations

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

- Annual routine vision exam \$15; not subject to deductible.
- Skilled nursing facility services limited to 100 days per benefit period.
- Home health care services limited to 100 visits per benefit period.
- Physical and occupational therapy services limited to a combined 30 visits per benefit period.³
- Speech therapy services limited to 30 visits per benefit period.³
- Spinal manipulations and other manual medical intervention visits limited to 30 visits per benefit period.
- Early intervention services unlimited per member per calendar year from birth through age 2.
- Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder is unlimited per member per benefit period for age two through age ten.
- Wigs limited to 1 wig per member per year.

¹ Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

² Additional limitations and exclusions may apply. For a complete list of exclusions and limitations, please refer to your Evidence of Coverage. Some covered services may require pre-approval.

³ Speech, physical and occupational therapies are unlimited for Early Intervention and Autism Spectrum Disorder.

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

Your prescription drug plan

Pharmacy network

Our prescription drug program manages more than 400 million prescriptions each year. With a broad retail pharmacy network, home delivery and a specialty unit that dispenses high-cost, biotech therapies, our comprehensive approach helps you manage your pharmacy benefits.

Your plan has a tiered drug list/formulary, or list of covered medications, which assigns drugs to specific tiers based on cost. Tier 1 drugs have the most affordable copay. Tier 2 drugs cost slightly more, and Tier 3 drugs have the highest copay amounts.

Pharmacy Benefits

For the Standard POS and Premier POS plans, you have a \$150 deductible per member per calendar year or \$150 deductible per calendar year for the whole family toward drugs on all tiers. Your deductible amount begins anew each calendar year. After you meet your deductible, you pay the appropriate copayment shown in the chart below for each prescription.

For the Lumenos® with HSA Plan: you have an overall plan deductible of \$3,000 per person/\$6,000 per family. This deductible applies to all covered medical services and prescription drugs on all tiers. Your deductible amount begins anew each calendar year. After you meet your deductible, you pay the appropriate copayment shown in the chart below for each prescription.

Your Prescription Drug 10-30-55 Plan*	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating pharmacies	\$10	\$30	\$55
Up to a 90-day medication supply delivered to your home	\$10	\$60	\$165
Up to a 90-day medication supply purchased at a participating** retail pharmacy	\$30	\$90	\$165

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

Retail 90 Pharmacy

Retail 90** is a unique network that offers more ways for you to get the maintenance medications you need. Maintenance medications are drugs taken on an ongoing basis for conditions such as asthma, diabetes or high cholesterol. Through Retail 90, you can choose to get a 90-day supply of medications from a participating retail pharmacy.

**Approximately 98% of the pharmacies in our network participate in the Retail 90 program. Be sure to check with your local pharmacy to verify their participation status prior to placing your 90 day retail prescription order.

To make sure your pharmacy's in our network, visit anthem.com and select Find a Doctor which will take you to the list of providers, pharmacies and hospitals who participate in our network.

Your prescription drug plan (continued)

Generic medications are Mandatory

Prescription drugs will always be dispensed as ordered by your physician. If your physician requires that you take the brand name drug instead of the generic drug, it will be covered at the applicable copayment. However, if you elect the brand name drug when a generic is available, you will pay your usual copayment for the generic drug plus the difference in the allowable charge between the generic and brand name drug.

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

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

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

Why generics cost less

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

Retail pharmacy network

Our network includes more than 70,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

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

- Log in and click on **Prescription Benefits** to go to our Pharmacy Overview page.
- Click on **Locate a Pharmacy**. You will be directed to the Express Scripts website.
- Enter your zip code.

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

- Log in and click on **Prescription Benefits** to go to our Pharmacy Overview page
- Click the **Additional Pharmacy Resources** link. You will be directed to the Express Scripts website.
- Hover over the **Health & Benefits Information** tab and click **Print Forms**.
- Click on the **printing the retail prescription claim form online** link.

Note about your pharmacy information on the web:

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

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

Your prescription drug plan (continued)

Home Delivery Pharmacy

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

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

Getting started with home delivery

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

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

- Log in and click on **Prescription Benefits** to go to our Pharmacy Overview page.
- Click the Switch to Mail Delivery link. You will be directed to the Express Scripts website.
- Hover over the **Health & Benefits Information** tab and click **Print Forms**.
- Click the link at the top of the page where it says to 'Print a mail order form'
- Mail your completed form, prescription from your doctor for a 90 day supply, and payments to:

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

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

Ordering refills

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

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

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

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

Online: Visit www.anthem.com.

- Log in and click on **Prescription Benefits** to go to our Pharmacy Overview page.
- You will be directed to the Express Scripts website.

Your prescription drug plan (continued)

Specialty Pharmacy

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

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

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

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

Ordering specialty drugs

You can place your first order by phone or fax:

By phone: Call **800-870-6419**, Monday through Friday, 8 a.m. to 9 p.m. and Saturday 9 a.m. to 1 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your ID card to **800-824-2642**.

Ordering refills

Online: Visit www.anthem.com.

- Log in and click on **Prescription Benefits** to go to our Pharmacy Overview page.
- Click the **Specialty Pharmacy Resources** link. You will be directed to the Express Scripts website.
- Click the Learn more about Specialty Pharmacies link to access a list of FAQs, including how to start using our exclusive specialty pharmacy.

By phone: Call the phone number on the back of your member ID card. You will be transferred to the home delivery pharmacy to get started.

Your prescription drug plan (continued)

Drug list

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

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

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit: www.anthem.com

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

Smoking Cessation Drug Coverage

The Plan also covers prescription smoking cessation medications and over-the-counter (OTC) nicotine replacement products with a prescription from your doctor. For those 18 years and older, 100% coverage of tobacco cessation products is provided for select FDA-approved generic products, brand-name products with no generic alternatives, and approved over-the-counter generic products. This requires a prescription from a doctor that must be presented at an in-network pharmacy. A 30 day supply of OTC nicotine replacement products may be obtained at retail pharmacies only.

Prescription smoking cessation coverage includes a 30 day max supply at retail pharmacies and 90 day max supply through Express Scripts home delivery. For those drugs not covered at 100%, the following will apply. If your physician requires that you take the brand name drug instead of the generic drug, it will be covered at the applicable copayment. However, if you elect the brand name drug when a generic is available, you will pay your usual copayment (after the deductible on Lumenos HSA plan) for the generic drug plus the difference in the allowable charge between the generic and brand prescription smoking cessation medications.

Over-the-Counter Prescription Drugs

The Plan also covers select over-the-counter (OTC) drugs at the Tier 1 copay, provided you obtain a prescription from your Physician. A 30-day supply is available per prescription at local participating retail pharmacies only.

Covered OTC medications include:

- lansoprazole (generic equivalents of Prevacid OTC®)
- omeprazole (generic equivalents of Prilosec OTC®/Zegerid OTCTM)
- cetirizine (generic equivalents of Zyrtec OTC®)
- fexofenadine (generic equivalents of Allegra OTC®)
- loratadine (generic equivalents of Claritin OTC®/Alavert OTC®)
- Alaway™
- Zaditor®
- Miralax OTC®

In addition, the following OTC items are covered at 100% when you present a prescription from your doctor at an in-network pharmacy:

- Iron supplements for children 0-12 months
- Fluoride supplements for children from birth through 6 years old
- Folic acid for women 55 years old or younger
- Aspirin for men between age 45-79
- Aspirin for women between age 55-79
- Vitamin D for women over 65

Prior authorization

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

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

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

The Drug List also includes this information. To view it, visit: www.anthem.com

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

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

This benefits overview insert is only one piece of your entire enrollment package. See the list of your plan's exclusions and limitations included in this enrollment guide.

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

Tips for understanding your coverage

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

Services that require advance reviews

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

Balance billing

If you receive care from hospitals and/or providers who have not contracted with us, they can charge whatever they want for their services. If what they charge is more than providers in our network have agreed to accept for the same service, you can be billed for the difference. This is called “balance billing.”

The best way to avoid balance billing is to:

- use in-network doctors, hospital and other providers, including labs and x-ray facilities;
- know what services are covered by your health plan; and
- make sure to get prior authorization for a medical service, if required.

Ins and outs of coverage

The ins and outs of coverage

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

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

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

Who can be enrolled

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

- Your spouse
- Your children until reaching age 26, including a newborn, biological child, adopted child, child placed with you for adoption; see the Plan Document details.

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

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

Your Anthem HealthKeepers plan can be ...

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

The ins and outs of coverage (continued)

Members will need to notify their Benefits Office if a dependent loses eligibility for coverage, such as a former spouse at divorce, or a child over age 26.

Special enrollment periods

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

When you're covered by multiple plans

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

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

Special Note for Lumenos HSA plan

The IRS and U.S. Treasury have very specific rules on who can elect a high deductible health plan with an HSA. You are not eligible to elect an HSA if you are:

- Enrolled in health insurance other than an HSA-compatible health plan, including an FSA
- Enrolled in Medicare or TriCare, or received VA Benefits in the last three months
- Claimed as a dependent on someone else's tax return
- Active military

The ins and outs of coverage (continued)

How benefits apply when Medicare-eligible

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

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

Recovery of overpayments

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

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

The ins and outs of coverage (continued)

What's not covered (exclusions)

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

acupuncture unless otherwise specified

services not **authorized in advance** by us and pre-arranged by your primary care physician unless otherwise specific in this book

biofeedback therapy

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

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

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

- shortening or lengthening of the mandible or maxillae for cosmetic purposes
- surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services
- dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia
- medications to treat periodontal disease
- treatment of natural teeth due to diseases
- biting and chewing related injuries; unless the chewing or biting results from a medical or mental condition
- restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth
- anesthesia and hospitalization for dental procedures and services **except** 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 provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

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

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

family planning

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

services for palliative or cosmetic **foot** care

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

gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Experimental ... or not?

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

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

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

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

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

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

home care services

- homemaker services (except as rendered as part of Hospice care)
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services

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

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

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

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

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

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

mental health and substance abuse

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

non-medically necessary services and supplies as determined by Anthem at its sole discretion. Notwithstanding this exclusion, all preventive care and hospice care services described in the benefits summary that is included in this booklet are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by Anthem to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services provided by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent a member from being able to appeal the Anthem's decision that a service is not medically necessary.

nutritional counseling and related services, except as specifically provided by the health plan or when provided as part of diabetes education, for treatment of an eating disorder, or when received as part of a covered preventive care visit.

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

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

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

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

paternity testing

prescription drug benefits

- over-the-counter drugs (except as noted within the prescription drug benefits section of this enrollment book)
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the allowable charge for that prescription
- drugs for weight loss
- stop smoking aids except as specifically outlined in the pharmacy section of this booklet
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- infertility medication
- any refill dispensed after one year from the date of the original prescription order
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies
- medicine furnished by any other drug or medical service
- Mail-order providers other than our home delivery mail-order provider. Prescription drugs dispensed by any mail order provider other than our mail order provider unless we must cover them by law
- Off label use, unless we must cover the use by law or if we approve it
- Drugs for Onychomycosis (toenail fungus), except when we allow it to treat members who are immuno-compromised or diabetic

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

- Compound drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants

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

services or supplies or devices

- received from providers not licensed by law to provide *covered services* defined in this Booklet. Examples include masseurs (massage therapists), physical therapist technicians and athletic trainers
- not listed as covered under your health plan
- not prescribed, performed, or directed by a provider licensed to do so
- received before the effective date or after a covered person's coverage ends
- for injuries or illnesses incurred as a result of your commission of, or attempt to commit, a crime
- services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self
- benefits for charges from stand-by physicians in the absence of covered services being rendered
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies if provided or available to a member:

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

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

- amounts above the allowable charge for a service
- for which a charge is not usually made, including those not typically charged to members without coverage
- self-administered services or self care including self-administered injections
- self-help training
- neurofeedback, and related diagnostic tests

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

services or supplies primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered preventive care visit or screening

sexual dysfunction (male and female sexual problems) services or supplies, including medical and mental health services

skilled nursing facility stays

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

smoking cessation programs not affiliated with us

spinal manipulation and manual medical therapy services (chiropractic care)

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

telemedicine

- non-interactive telemedicine services, such as audio only telephone conversations, electronic mail message, facsimile transmission or online questionnaire.

therapies

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- group speech therapy

These services are not covered by your Anthem HealthKeepers plan.

The ins and outs of coverage (continued)

- group or individual exercise classes or personal training sessions
- recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

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

vision services (except as provided through Blue View Vision)

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

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

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

These services are not covered by your Anthem HealthKeepers plan.

Additional benefits

Blue View VisionSM

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

Advantages of Anthem Blue View Vision:

- **You have access to eye doctors close to you.** Blue View Vision has 50,000 eye doctors and locations in its network. If you don't already have a favorite, you can quickly find one. Plus, many retail locations, like LensCrafters®, Target® Optical, Sears Optical, JCPenney Optical and Pearle Vision®, are covered by the plan. Finding a Blue View Vision network provider is easy – simply visit www.anthem.com.
- **You can get an eye exam every year.** Blue View Vision helps pay for eye exams annually.
- **Not many plans are this simple.** Just schedule an appointment with a network provider and present your member ID card when you arrive. The doctor's office staff will take care of the rest.
- **You save even more with additional discounts.** Want a frame that costs more than your plan allows? You save 20 percent off the balance. Want spare glasses, contact lenses or prescription sunglasses? Save 15 to 40 percent. Your additional discounts are unlimited – even after your vision care benefits have exhausted.

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

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

This is a brief overview of your plan's features. Your summary of benefits contains the details.

**WELCOME TO
BLUE VIEW VISION!**

This summary outlines the basic components of your vision plan, including quick answers about what's covered, your discounts and much more!



Henrico County General Government and Schools

Blue View VisionSM Exam Only A15 Plan

Your Blue View Vision network

Blue View Vision offers one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. Best of all - when receiving care from a Blue View Vision participating provider, you can maximize benefits and money-saving discounts.

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Routine eye exam - once every calendar year	\$15 copay, then covered in full	\$30 allowance
Retinal Imaging - at member's option can be performed at time of eye exam	Discounted member cost up to \$39	Discount not available
Contact lens fitting and follow-up - a contact lens fitting and two follow-up visits are available once a comprehensive eye exam has been completed.		
Standard contact lens fitting ¹	Covered in full	\$35
Premium contact lens fitting ²	10% off retail price, then apply \$55 allowance	\$35

ADDITIONAL SAVINGS ON EYEWEAR AND MORE

Blue View Vision members can take advantage of valuable discounts through our Additional Savings program. When visiting a participating Blue View Vision eye care professional or vision center, you can enjoy 35% off the retail price of eye glass frames and 15% off the retail price of conventional (non-disposable) contact lenses. You can also save 20% off the retail price of non-prescription sunglasses and eye care accessories. Plus you'll get special member savings on standard eyeglass lenses, lens treatment options and upgrades. Restrictions may apply and discounts are subject to change without notice.

OUT-OF-NETWORK

If you choose, you can receive care outside of the Blue View Vision network. You simply get an allowance toward your covered services and you pay the rest. In-network benefits and discounts will not apply. When visiting an out-of-network provider, you are responsible for payment of services at the time of service. If you choose an out-of-network provider, you will need to complete the out-of-network claim form and submit it along with your itemized receipt via any of the following methods:

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

EXCLUSIONS & LIMITATIONS

This is a primary vision care benefit and is intended to cover only eye examinations. If medical treatment of the eyes is needed, you should visit a participating eye care physician from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force.

<p>Combined Offers. Not combined with any offer, coupon, or in-store advertisement.</p> <p>Experimental or Investigative. Any experimental or investigative services.</p> <p>Uninsured. Services received before insured person's effective date or after coverage ends.</p> <p>Excess Amounts. Any amounts in excess of covered vision expense.</p> <p>Eyewear. Any type of eyewear and related materials including eyeglass lenses, frames, or contact lenses.</p> <p>Routine Exams or Tests. Routine examinations required by an employer in connection with insured person's employment.</p> <p>Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.</p> <p>Government Treatment. Any services actually given to the insured person by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if insured person is not required to pay for them or they are given to the insured person for free.</p> <p>Services of Relatives. Professional services or supplies received from a person who lives in insured person's home or who is related to insured person by blood or marriage.</p>	<p>Voluntary Payment. Services for which insured person is not legally obligated to pay. Services for which insured person is not charged. Services for which no charge is made in the absence of insurance coverage.</p> <p>Not Specifically Listed. Services not specifically listed in this plan as covered services.</p> <p>Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.</p> <p>Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.</p> <p>Hospital Care. Inpatient or outpatient hospital vision care.</p> <p>Orthoptics. Orthoptics or vision training and any associated supplemental testing.</p> <p>Crime or Nuclear Energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available.</p>
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¹A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

²A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

All terms and conditions of coverage, including benefits and exclusions, are contained in the member's Policy, which shall control in the event of a conflict with this overview. Frame discounts associated with this vision plan may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice.

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

Health, wellness & Anthem advantages

Get the most out of your health plan

www.anthem.com

Clear. Intuitive. Easy.

Save money and live better with tools that keep you informed, in control, and at your healthy best.

Health and wellness

Now it's easier than ever to improve your health and well-being. Simply log in at www.anthem.com. You have access to an array of innovative tools to help you manage your health and achieve your goals.

MyHealth Assessment

Your first step toward a healthier lifestyle

Gain personal insights into your current health, your health risks, and what you can do to enjoy a healthier life. You complete a confidential assessment of your health and health care status, then receive a health assessment score and risk profile based on your specific answers. You also get tips and actions to help you improve your health.

To use MyHealth Assessment:

- Visit www.anthem.com
- Click on "Health & Wellness"
- Under Health Assessment, select "Take my HA now"

MyHealth Record

Your health history in one secure location

Keep your medical records organized, secure and easily accessible for emergencies and everyday use. Enter your information such as dates of immunizations, tests and screenings, prescription and over-the-counter drugs you take, medical conditions and more. Print and share with your doctors to help avoid potential drug interactions and duplicative tests and procedures.

To use MyHealth Record:

- Log in at www.anthem.com
- Click on "Health & Wellness"
- Under Health Assessment, select "Start your Health Record"

LiveHealth Online

With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed. With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of board-certified doctors.
- Private, secure and convenient online visits.
- Members who register, pay the following:
 - Premier Plan - \$10 copay
 - Standard Plan - \$15 copay
 - Lumenos - \$49 fee
(this goes toward your deductible if you haven't met it)

To enroll, download the free app on your mobile device and complete the About You page. Or sign up on your computer at livehealthonline.com.

Get the most out of your health plan

LiveHealth Online Psychology

An easy, convenient way to see a therapist or psychologist in just a few days.

If you're feeling stressed, worried, or having a tough time, you can talk to a licensed psychologist or therapist through video using **LiveHealth Online Psychology**. It's easy to use, private and, in most cases, you can see a therapist within four days or less.³ All you have to do is sign up at **livehealthonline.com** or download the app to get started. The cost is similar to what you'd pay for an office therapy visit.

Make your first appointment – when it's easy for you

- Use the app or go to **livehealthonline.com** and log in.
- Select **LiveHealth Online Psychology** and choose the therapist you'd like to see. Or, call LiveHealth Online at **1-844-784-8409** from 7 a.m. to 11 p.m. You'll get an email confirming your appointment.
- You pay the following:
 - Premier Plan - \$20
 - Standard Plan - \$25
 - Lumenos - Costs are \$95 for a session with a PhD Psychologist and \$80 for a session with a Licensed Social worker. This goes toward your deductible if you haven't met it.

Note: Appointments subject to availability of a therapist.

Special Offers

Discounts on health-related products and services

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids, and audiology services, fitness center memberships, weight-loss programs and more.

To access all discounts:

- Log in at www.anthem.com
- Click on "Health & Wellness"
- On far right side of page, see "Discounts"
- Click on "Access your Discount"

Patient Ratings & Reviews

Doctor recommendations from your peers

Picking a doctor is one of the most important choices you make for your health care. When you find the right one, it can make all the difference in the world and lead to better care and better health. Use our improved Patient Ratings & Reviews tool to see ratings and comments from other patients who have seen a doctor. It can help you make the right choice for you.

Patient Ratings and reviews can be found on www.anthem.com. Choose Find a Doctor, search for a doctor, and see what ratings are available and what others have to say.

Not registered at www.anthem.com?

Sign up now for access to personalized service and resources. It's fast, easy and secure.

Health and Wellness programs

The programs you read about here come with your health plan. There is no extra cost for them.

To learn more about these programs online, log in to www.anthem.com and select the Health and Wellness tab.

Take charge of your health and the choices you make

We all have different health needs. Maybe you're fit and want to stay that way. Maybe you're living with a chronic condition like asthma. Or maybe you fall somewhere in between. No matter where you fall, our Health and Wellness programs are here to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, we can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

24/7 NurseLine

Within the Emergency and urgent care section, we told you about the 24/7 NurseLine that comes with your plan to help you with any health care decisions you need to make, any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach 24/7 NurseLine, call 1-800-337-4770 if you're enrolled in the Standard POS or Premier POS plan. If you're enrolled in the Lumenos with HSA plan, call 1-866-800-8780.

Future Moms

We know your goal is to have a safe delivery and a healthy baby. That's why we offer Future Moms, a voluntary program to help you take care of your baby before you deliver. Register for Future Moms and you'll get:

- 24/7 access to talk to a nurse coach about your pregnancy, newborn care and much more. Each future mom (and dad) has round-the-clock access
- A maternity care diary packed with tips for a healthy pregnancy. There's also space to track your doctor's appointments, and changes in your body and feelings during your pregnancy.
- A copy of the best-selling book, *Mayo Clinic Guide to a Healthy Pregnancy*.

Enroll in Future Moms by calling 1-866-664-5404 if you're enrolled in the Standard POS or Premier POS plan. If you're enrolled in the Lumenos with HSA plan, call 1-866-347-8360.

Health and Wellness programs

ConditionCare

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

Information and support are as close as your phone. To speak to a ConditionCare Nurse, just call 1-800-445-7922 if you're enrolled in the Standard POS or Premier POS plan. If you're enrolled in the Lumenos with HSA plan, call 1-866-577-9443.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

Here's how it works: We review your health status daily and check to see what medications you're taking. If we see that any of your medicines could interact with each other, we tell your doctor right away. We also keep track of when you need to get routine tests and checkups. We send you a reminder called a "MyHealth Note" when you should make these appointments. MyHealth Note has a summary of all your recent claims. And from time to time, we give you tips on how to save you money on your medications.

Healthy Lifestyles

Healthy Lifestyles is a free online program that gives you support and rewards to help you stay healthy or get healthier. Whether you want to quit smoking, lose weight, eat right, exercise more or manage stress, Healthy Lifestyles makes it easy to set goals, track your progress and earn rewards. With Healthy Lifestyles, you can:

- Sign up for a program to quit smoking
- Use nutrition and fitness trackers
- Find healthy recipes
- Join community and online forums
- Get discounts on massages, gym memberships, spa services and more

A healthier lifestyle can be just a mouse click away. To learn more, visit www.anthem.com.

Information you should know

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

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

Utilization Management

Utilization Management (UM) is a program that is part of your health plan that lets us make sure you're getting the right care at the right time. Our UM program is made up of a team of licensed health care professionals such as nurses and doctors who do medical reviews. The UM review team goes over the information we have received from your doctor or other health care provider to see if a surgery, treatment or other type of care that has been requested is medically needed. The UM review team checks to make sure that the treatment meets specific rules set by your health plan. After reviewing the records and information, the surgery or treatment will be approved (covered) or denied (not covered) and the UM review team will let you and your doctor know as soon as possible.

Medical reviews like this can be done before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before medical care is given)

A prospective review is done before a member goes to the hospital or has some other type of service or treatment.

Here are some types of medical needs members may have that might call for a prospective review:

- To go to (and/or stay at) a hospital
- An outpatient procedure (the member can go home the same day)
- Tests done to try to find the cause of an illness such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans
- A certain type of outpatient therapy such as physical therapy or emotional health counseling
- "Durable medical equipment" (DME) which means wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

A concurrent review is done at the time the member is in the hospital or is released and needs more care related to the hospital stay. This could mean services or treatment done in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment (see above), staying in a nursing home, getting emotional health care and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

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

The retrospective or post-service review (done after medical care is given)

A retrospective review is done when a member has already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at the member's medical information that the doctor or provider had at the time the medical care was given. They can then see if the treatment was medically needed.

Case Management

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

Your rights and responsibilities as an Anthem HealthKeepers member

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

You have the right to:

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

Your rights and responsibilities as an Anthem HealthKeepers member (continued)

You have the responsibility to:

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

Let Henrico General Government or Public Schools know if you have any changes to your name or address, or if any of your covered dependents are no longer eligible for coverage (for example, divorced spouse or child reaching age 26).

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

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

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

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

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

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

Your Protected Health Information

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

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

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

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

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

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

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

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

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

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

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

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

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

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

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

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

Potential Impact of Other Applicable Laws

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

Complaints

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

Contact Information

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

Copies and Changes

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

Important legal information you should take time to read

Please refer to the Plan document for the County of Henrico Health Plan for additional details about the Plan.

This Notice is provided by the following company: HealthKeepers, Inc., an affiliate of Anthem Blue Cross and Blue Shield.

STATE NOTICE OF PRIVACY PRACTICES

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

Your Personal Information

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

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

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

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

You have the right to access and correct your PI.

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

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

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

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

This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Plan Document for County of Henrico Health Plan, the provisions of the Plan Document for County of Henrico Health Plan will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031

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County of Henrico
General Government



Anthem HealthKeepers

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