Henrico County General Government and Public Schools

2022 POS and HDHP with HSA plans
Healthcare Benefits Enrollment Guide

Anthem
And Its Affiliate HealthKeepers, Inc.

County of Henrico
General Government

HCPS
Henrico County Public Schools

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

Fast facts

Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. have been serving the healthcare 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."

When you and your family need a doctor, it's important to find one that suits your needs. We are always trying to improve and grow our networks. More doctors than ever before are caring for patients through our HealthKeepers network. Our HealthKeepers network of doctors has grown throughout Virginia and is now Statewide.

serving for
75+
years

members in
14
states

7,000
employees in VA

52,000+
employees nationwide

38,000M
members served

roughly one in every nine Americans

Welcome to Anthem HealthKeepers benefits

We're glad you're taking time to check out all that Anthem HealthKeepers has to offer. 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. It's a snapshot of the benefits that come with Anthem HealthKeepers coverage. It shows what's available to you, what you receive 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 it easier to explore the advantages of being an Anthem HealthKeepers member:

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

Registering on anthem.com is step one

Once you receive your ID card, you can register online in five minutes. After you register at **anthem.com**, you can use 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, and learn about doctors and hospitals.

- Go to **anthem.com**
- Select the **Register now** link and follow the instructions to create your user name and password.

This guide can help you choose your benefits with confidence. If you have questions, your benefits manager will be happy to answer them. Thanks for considering Anthem HealthKeepers.

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

Important phone numbers

Member Services
833-630-6742 Eastern Standard Time
Monday to Friday, 8 a.m. to 6 p.m.

24/7 NurseLine
800-337-4770

BlueCard Access
(for information while you're traveling out of state)
800-810-2583

Guest Membership
866-823-5391

Advanced Diagnostic Imaging Benefit
(applies to Standard POS and Premier POS plans only)
Call Member Services at 833-630-6742

For HDHP Member Pharmacy Services
833-262-1729

Provider Services
(in case your doctor needs to contact Anthem to coordinate a service for you or obtain an authorization)
833-630-6742

Pre-Authorization
(for members who choose to go out-of-network)
833-630-6742

Mental Health Services
(for services requiring pre-authorization)
800-991-6045

B**lue View Vision**
Call Member Services at 800-630-6742

Visit us at anthem.com

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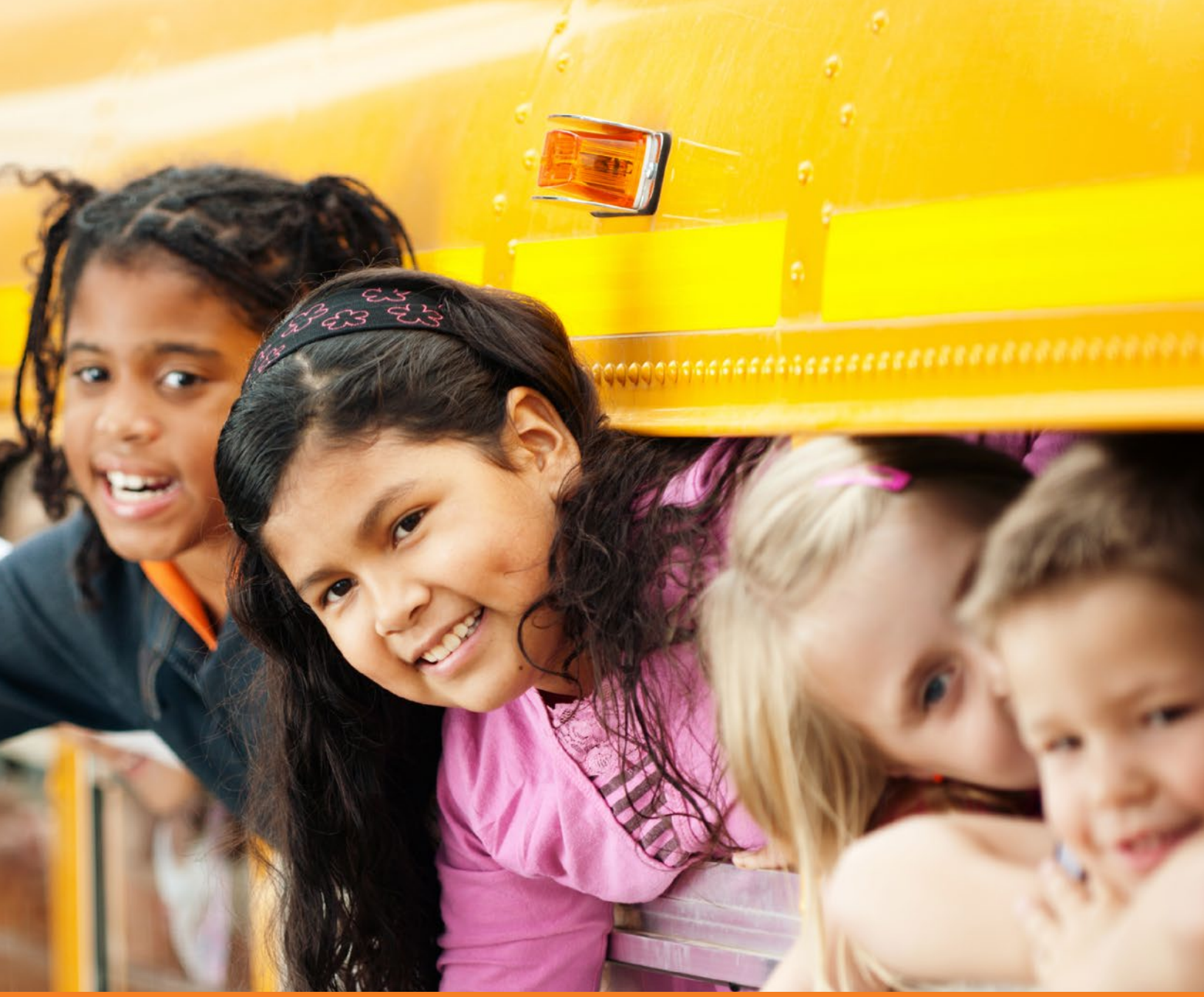

Your health benefits

Your member ID card

Your Member ID card is the first step in using your healthcare. 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, 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 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 **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.

Stay on top of your health

Use your preventive care benefits

Regular checkups and exams can help you stay healthy and catch problems early, when they are easier to treat. Our health plans offer all the preventive care services and immunizations below at no cost to you.[1] As long as you use a plan doctor, pharmacy, or lab, you will not have to pay anything. If you use providers that are not in your plan, you may have out-of-pocket costs.

If you are not sure which services make sense for you, talk to your doctor.

Preventive versus diagnostic care

Preventive care helps protect you from becoming sick. If your doctor recommends services even though you have no symptoms, that is preventive care. Diagnostic care is when you have symptoms and your doctor recommends services to find out what is causing your symptoms.

Adult preventive care

Preventive physical exams, screenings, and tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (for men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) levels
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)[2]
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection, and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening[3]
- Eye chart test for vision[4]
- Hearing screening
- Height, weight, and body mass index (BMI)
- Human immunodeficiency virus (HIV) screening and counseling
- Lung cancer screening for those ages 55 to 80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years[2]
- Obesity: related screening and counseling[3]
- Prostate cancer, including digital rectal exam and prostatespecific antigen (PSA) test
- Sexually transmitted infections screening and counseling
- Tobacco use: related screening and behavioral counseling
- Tuberculosis screening
- Violence, interpersonal, and domestic: related screening and counseling

continued **»**

Stay on top of your health *(continued)*

Use your preventive care benefits

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA1 and BRCA2 when certain criteria are met[5]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies, and counseling[5,6,7,8]
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those at high risk for breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- Human papillomavirus (HPV) screening
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV, and depression[7]
- Pelvic exam and Pap test, including screening for cervical cancer

Immunizations:

- Coronavirus (COVID-19)
- Diphtheria, tetanus, and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps, and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles)

Child preventive care

Preventive physical exams, screenings, and tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid levels
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight, and BMI
- Hemoglobin or hematocrit (blood count)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Skin cancer counseling for those ages 10 to 24 with fair skin
- Oral (dental health) assessment, when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening, when done as part of a preventive care visit[4]

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type b (Hib)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Meningitis
- Measles, mumps, and rubella (MMR)
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

Coverage for pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules.
- Get prescriptions from plan providers and fill them at plan pharmacies.
- Have prescriptions, even for OTC items.

Adult preventive drugs and other pharmacy items (age appropriate)

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease (CVD), preeclampsia, and colorectal cancer in adults younger than 70 years of age
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Generic low-to-moderate dose statins for members ages 40 to 75 who have one or more CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking)
- Tobacco-cessation products, including all FDA-approved brand-name and generic OTC and prescription products, for those ages 18 and older
- Preexposure prophylaxis (PrEP) for the prevention of HIV

Child preventive drugs and other pharmacy items (age appropriate)

- Dental fluoride varnish to prevent the tooth decay of primary teeth for children ages 0 to 5
- Fluoride supplements for children ages 0 to 6

Women's preventive drugs and other pharmacy items (age appropriate)

- Contraceptives, including generic prescription drugs, brandname drugs with no generic equivalent, and OTC items like female condoms and spermicides[7]
- Low-dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women ages 55 or younger who are planning and able to become pregnant
- Breast cancer risk-reducing medications, such as tamoxifen, raloxifene, and aromatase inhibitors, that follow the U.S. Preventive Services Task Force criteria[2]

We hope this information helps you understand your preventive care benefits. For a complete list of covered preventive drugs under the Affordable Care Act, view the Preventive ACA Drug List flyer, available at **anthem.com/pharmacyinformation**.

The preventive care services listed above are recommendations of the Affordable Care Act (ACA) and therefore are subject to change. They may not be right for every person. Ask your doctor what's right for you.

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there are differences between this sheet and the group policy, the provisions of the group policy will rule. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for exclusions and limitations.

1 The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on 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 Health Resources and Services Administration (HRSA) guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

2 ou may be required to receive preapproval for these services.

3 The Centers for Disease Control and Prevention (CDC)-recognized diabetes prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

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

5 Check your medical policy for details.

6 Breast pumps and supplies must be purchased from plan providers for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

7 This benefit also applies to those younger than age 19. A cost share may apply for other prescription contraceptives, based on your drug benefits. Your cost share may be waived if your doctor decides that using the multisource brand or brand name is medically necessary.

8 Counseling services for breastfeeding (lactation) can be provided or supported by a plan doctor or hospital provider, such as a pediatrician, OB-GYN, or family medicine doctor, and hospitals with no member cost share (deductible, copay, or coinsurance). Contact the provider to see if such services are available.

Vaccines are important

Vaccines are important. They not only prevent disease, 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.

If you're enrolled in HDHP, your Prescription Program covers the drugs listed below with a prescription from your doctor. Call a participating pharmacy to make sure a certified immunizing pharmacist is on duty and your vaccine is in stock. Visit **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 — Shingrix
- Pneumococcal — Pneumovax
- Influenza — Fluzone, Fluvirin, others

Other immunizations are available, based upon age-appropriate guidelines. Flu shots for 2022:

- A single shot protects against Influenza.
- Flumist and Fluzone HD are excluded from coverage.
- $0 copay at pharmacies that participate in the Anthem Healthcare/Vaccine Program.
- For the HDHP 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.

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 thousands of dollars depending on where you go for these services. Different places charge different prices for their imaging services, but a higher price doesn't mean higher quality. There are several doctors in your plan's network who provide quality imaging services (typically MRIs, MRA, CTA, and CT Scans) in their offices. That's why we encourage 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 preauthorized 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. Keep this in mind if you need one of these tests.

Here's how the benefits will work and your cost for each setting:

Imaging services	Standard POS	Premier POS
Office Setting	10% after deductible	5% after deductible
Other setting (free-standing or outpatient department of a hospital)	30% after deductible	5% after deductible

You can view other cost and quality data on your own by logging onto the **www.anthem.com/account-login**. Once you're logged in, select the Estimate Your Costs tool. 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 receive 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

5. Go to **anthem.com** to find a listing of available providers.
6. Select **Menu** and then choose **Find a Doctor**.
7. Answer questions that can help us find you the right plan and doctor in your plan.
8. Enter or select the plan/network.*
9. Select a type of provider, place or name.
10. Select Search.

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

Sydney, Anthem's mobile app — your benefits at your fingertips

Using our mobile app can make it easier to manage your healthcare. You can do things like:

1. Find a doctor.
2. Receive your ID card.
3. Check your claims.
4. Estimate your costs.

To download the app:

1. Go to the App Store® or Google Play™ on your mobile device.
2. Search for **Sydney Anthem**.
3. Select the app and download for free.

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.

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

Emergency and urgent care

Our plans provide coverage for medical emergencies, no matter where they occur. It's 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. Go to the nearest participating hospital emergency room (ER). Hospital ERs that are not in your plan's network should only be used if the delay receiving care from a participating ER could 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 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. You can also call the 24/7 toll-free NurseLine to speak with a registered nurse who will advise you on where to go.

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 if you elect a Patient First physician as your PCP. Otherwise, you may be charged the Specialist copayment. For the HDHP 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 **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.

continued **»**

Emergency and urgent care *(continued)*

Medical emergency examples

Other examples of a medical emergency include:

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

What is not a medical emergency?

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

- Coughing
- Diarrhea
- Sore throat
- Colds
- Stomach ache
- Rashes
- Vomiting
- Earache
- Toothache
- Pink eye
- Mild fever
- 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. Other examples of urgent care are:

- Sprains
- Non-severe bleeding
- General 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. 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. It can also safeguard your health and the health of your family.

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

Comparison of emergency and urgent care			
Type of service	**Standard POS Open Access**	**Premier POS Open Access**	**HDHP 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 urgent care center	$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%
For a complete list of available urgent care centers, visit **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 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 used 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 the area 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 **(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 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 19 states, in addition to Puerto Rico, that do not participate in this program: Alabama, Alaska, Idaho, Iowa, Kansas, Mississippi, Montana, Nebraska, North Dakota, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, and Wyoming. States that are covered are not always covered statewide, and other areas of a covered state may not be available.

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 US. You'll have access to medical care nearly anywhere you're staying.

Receiving medical care away from home is as convenient as accessing the local network:

1. Find a provider from the BlueCard listing. You can search online at **anthem.com** or call the Member Services number on the back of your member ID card.You can also call BlueCard Access at **800-810-BLUE (2583)**.
2. 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 a 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.

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 receive 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. You can view our demo at **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 HDHP HSA plan, it's very important to understand the upfront costs since you're responsible for the deductible first. Go to **anthem.com**, Member Log In and select Estimate Your Costs.

Small things add up.

People want to know how to get the absolute most from their benefits. They're experts at finding extra dollars in the corners and corridors of the healthcare 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 more in the ER than they would in your primary care or family doctor's office. For minor cuts and sprains, ear infections, urinary tract infections, and bronchitis, you would save money by avoiding the ER. 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 when you need care — 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 (applies to HDHP with HSA plan only)

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. **Note:** if your actual prescription costs less than the copayment, you'll pay the lower amount.

Action Step #6: Choose generic over brand-name (applies to HDHP with HSA plan only)

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 they are available and appropriate for your treatment or condition. If they aren't, your doctor may still know of lower-cost brand-name alternatives that would also work.

Action Step #7: Take advantage of 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 **anthem.com**, or by calling the Member Services number on your ID card.

Action Step #8: Keep an eye on your EOB

You'll receive 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 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 #9: 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 help you navigate the healthcare system and use your benefits wisely. And it's part of your plan at no extra cost.

Register today at anthem.com

From your computer:

- Go to **anthem.com** and select **Register Now**
- Provide the personal information requested
- 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**

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

Action Step #10: Use doctors and hospitals in your plan's network

They'll cost less than providers that aren't in your plan's network. 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 **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 #11: Get health tips from anthem.com

At **anthem.com**, you'll find expert information to help you stay on top of your healthcare options, costs and ways to improve your health. 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. In-network care will usually cost less than out-of-network care. The Anthem HealthKeepers network includes many doctors and hospitals across Virginia to help you find plenty of choices.

As an Anthem HealthKeepers member, you have access to several 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 receiving 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 percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

Through **anthem.com**, you can estimate the costs for inpatient and outpatient services and doctor visits.

You're covered whenever you travel

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

You have more than a health plan

You have programs that actually help you manage your health. Wellness tools, health management programs, and Family and Home Special Offers are all available through **anthem.com**. The programs are explained in detail later in this booklet. This is a brief overview of your plan's features. Your benefits summary contains the details.

HDHP with Health Savings Account (HSA)

Using your HDHP Plan with HSA

The HDHP 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.

This makes your HDHP 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, 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 a licensed doctor or hospital

With the HDHP with HSA plan, you can visit a 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.

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 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.

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. 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. You may have to file the claim 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 **anthem.com**.

How the HDHP with HSA plan works for prescriptions

Getting a prescription is convenient with the HDHP with HSA plan — especially when you consider 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 receive 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 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 healthcare dollars with generics

Want to save to 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.

Benefit comparison

January 1, 2022 – December 31, 2022

Anthem

	Standard POS	Premier POS	HDHP with HSA
IN-NETWORK BENEFITS			
Deductible (individual/family)	$300 / $300	$300 / $300	$3,000/$6,000 (combined with out of network)
Out-of-pocket maximum	Medical: $2,500/$5,000 Pharmacy: $500/$1,000	Medical: $2,500/$5,000 Pharmacy: $500/$1,000	Medical and pharmacy combined: $4,000 / $8,000
Inpatient benefits	**You pay**	**You pay**	**You pay**
Hospital	30% after deductible	5% after deductible	0% after deductible
Physician charges	30% after deductible	5% after deductible	0% after deductible
Maternity (Facility charges for delivery)	30% after deductible	5% after deductible	0% after deductible
Mental health and substance abuse (Facility charges)	30% after deductible	5% 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	5% after deductible	0% after deductible
Advanced diagnostic imaging: all other settings	30% after deductible	5% 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

Benefit comparison *(continued)*

January 1, 2022 – December 31, 2022

Anthem

	Standard POS	Premier POS	HDHP with HSA
	You pay	**You pay**	**You pay**
Outpatient surgery facility professional provider	30% after deductible	5% after deductible	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 healthcare (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	5% after deductible	0% after deductible
Hospice care	30% after deductible	5% after deductible	0% after deductible
Prescription drugs*	**Mandatory generic**	**Mandatory generic**	**Mandatory generic**
Rx deductible (individual/family)	$150/$150	$150/$150	Plan deductible applies
Retail pharmacy (30 day supply)	After deductible: $10/$30/$55	After deductible: $10/$30/$55	After deductible: $10/$30/$55
Mail order (90 day supply)	After deductible: $10/$60/$165	After deductible: $10/$60/$165	After deductible: $10/$60/$165
Retail 90 (90 day supply purchased at a participating retail pharmacy)	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	$2,500/$5,000	$2,500/$5,000	$6,000/$12,000
Lifetime maximum	**Unlimited**	**Unlimited**	**Unlimited**

* As of 1/1/18, prescription drug coverage for the Premier POS and Standard POS plans is being provided by Express Scripts Direct. If you're enrolled in the HDHP with HSA plan, your prescription drug coverage will continue to be provided by Anthem IngenioRx.

Your benefits

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	
• Office visits • Voluntary family planning • Wisdom teeth extractions *(bony impacted only)* • In-office surgery • Allergy testing	**$25** for each visit to your PCP or OB-GYN **$45** for each visit to a specialist
• Urgent care visits	**$25** for each visit to your PCP **$45** for each visit to a specialist
• Mammograms	**No Charge**
• Mental health and substance abuse visits	**$25** for each visit
• 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	
• Annual routine eye exam **Administered by Blue View Vision**	**$15** for each visit
Labs, diagnostic X-rays	
• Diagnostic tests • Diagnostic X-rays *(other than advanced diagnostic imaging services)* • Lab work *(provided through LabCorp)*	**No charge**
Maternity services	
• All routine outpatient pre-and postnatal care *(excluding inpatient stays)* • Diagnostic testing *(such as ultrasound, non-stress tests, and other fetal monitor procedures)*	**$50** per pregnancy No charge
Emergency care	
• True emergency care visits in or out of the service area *(waived if admitted directly to the hospital)*	**$150** for each visit to an emergency room
Early intervention — for children from birth through age two	
• Early intervention services	Member cost shares will be dependent on the services rendered
Autism Spectrum Disorder (ASD)	
• Diagnosis and treatment of autism spectrum disorder including: – Behavioral health treatment* – Psychological care – Psychiatric care – Therapeutic care** *** Mental health services** **** Unlimited physical, occupational, and speech therapy.**	Member cost shares will be dependent on the services rendered
Other outpatient services	
• Ambulance travel	**No charge**
• Physical, occupational, and speech therapy	**$45** for each visit
• Spinal manipulation and manual medical therapy services *(limited to 30 visits per plan year)* **Administered by American Specialty Group (ASG)**	**$25** for each visit
• Infusion therapy • Chemotherpay • Radiation therapy • Dialysis	**No charge**

Your benefits *(continued)*

Anthem HealthKeepers/Standard POS Plan/Open Access

All other services (subject to deductible)	
You will pay all the costs associated with your care until you have paid $300 per individual/$300 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	
• Semi-private room • Private room when approved in advance • Intensive or coronary care unit • Maternity services • Mental health and substance abuse services • Skilled nursing facility *(100 days for each admission)* • Occupational, speech and physical therapy	**30%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
Other outpatient services	
• Advanced diagnostic imaging services *(includes MRI, MRA, CTA and CT scans)* done in an office setting	**10%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services.
• 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 healthcare professionals in our network have agreed to accept for their services
• Surgery in a hospital or facility *(including bony impacted wisdom teeth extractions)*	**30%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
• Hospice care	**30%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
• Home healthcare *(limited to 90 visits per plan year)*	**$45** per visit after deductible
• Diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered after deductible
• Prosthetic devices	**30%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
• Durable medical equipment • Medical supplies	**No Charge** after deductible
• Cardiac rehab therapy	**30%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD)	
• Applied behavioral analysis	Member costs shares will be dependent on place of treatment and services rendered

Out-of-network services

Deductible for services received from out-of-network healthcare 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 healthcare professionals have agreed to accept for the same service. What you pay includes a difference between the fee our network healthcare professionals have agreed to accept for the same service and the amount the healthcare 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 $2,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay $2,500 ($5,000 total).
- If three or more people are covered under your plan, together you will pay $5,000. However, no family member will pay more than $2,500 toward the limit.

When using out-of-network professionals
If you are the only one covered by your plan, you will pay $2,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum.

- If two people are covered under your plan, each of you will pay $2,500 ($5,000 total).
- If three or more people are covered under your plan, together you will pay $5,000. However, no family member will pay more than $2,500 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
- The cost associated with prescription drugs

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

Specialist visits do not require PCP referral.

Other benefits may be subject to balance billing, if provided by a non-participating provider.
For more information on balance billing, see page 38 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 healthcare reform laws. As we receive additional guidance and clarification on the new healthcare 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/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	
• Office visits • Voluntary family planning • Wisdom teeth extractions *(bony impacted only)* • In-office surgery • Allergy testing	**$20** for each visit to your PCP or OB-GYN **$40** for each visit to a specialist
• Urgent care visits	**$20** for each visit to your PCP **$40** for each visit to a specialist
• Mammograms	**No Charge**
• Mental health and substance abuse visits	**$20** for each visit
• 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	
• Annual routine eye exam **Administered by Blue View Vision**	**$15** for each visit
Labs, diagnostic X-rays	
• Diagnostic tests • Diagnostic X-rays *(other than advanced diagnostic imaging services)* • Lab work *(provided through LabCorp)*	**No charge**
Maternity services	
• All routine outpatient pre-and postnatal care *(excluding inpatient stays)* • Diagnostic testing *(such as ultrasound, non-stress tests, and other fetal monitor procedures)*	**$50** per pregnancy No charge
Emergency care	
• True emergency care visits in or out of the service area *(waived if admitted directly to the hospital)*	**$150** for each visit to an emergency room
Early intervention — for children from birth through age two	
• Early intervention services	Member cost shares will be dependent on the services rendered
Autism Spectrum Disorder (ASD)	
• Diagnosis and treatment of autism spectrum disorder including: – Behavioral health treatment* – Psychological care – Psychiatric care – Therapeutic care** * **Mental health services** ** **Unlimited physical, occupational, and speech therapy.**	Member cost shares will be dependent on the services rendered
Other outpatient services	
• Ambulance travel	**No charge**
• Physical, occupational, and speech therapy • Spinal manipulation and manual medical therapy services *(limited to 30 visits per plan year)* **Administered by American Specialty Group (ASG)**	**$25** for each visit
• Infusion therapy • Chemotherpay • Radiation therapy • Dialysis	**No charge**

All other services (subject to deductible)	
You will pay all the costs associated with your care until you have paid $300 per individual/$300 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	
• Semi-private room • Private room when approved in advance • Intensive or coronary care unit • Maternity services • Mental health and substance abuse services • Skilled nursing facility (100 days for each admission) • Occupational, speech and physical therapy	**5%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
Other outpatient services	
• Advanced diagnostic imaging services *(includes MRI, MRA, CTA and CT scans)* done in an office setting	**5%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services.
• Advanced diagnostic imaging services *(includes MRI, MRA, CTA, PET scans and CT scans)* done in all other settings	**5%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
• Surgery in a hospital or facility *(including bony impacted wisdom teeth extractions)*	**5%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
• Hospice care	**5%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
• Home healthcare *(limited to 90 visits per plan year)*	**$40** per visit after deductible
• Diabetic supplies, equipment and education	Member cost shares will be dependent on the services rendered after deductible
• Prosthetic devices	**5%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
• Durable medical equipment • Medical supplies	**No Charge** after deductible
• Cardiac rehab therapy	**5%** after deductible of the amount the healthcare professionals in our network have agreed to accept for their services
Autism Spectrum Disorder (ASD)	
• Applied behavioral analysis	Member costs shares will be dependent on place of treatment and services rendered

Out-of-network services
Deductible for services received from out-of-network healthcare 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 healthcare professionals have agreed to accept for the same service. What you pay includes a difference between the fee our network healthcare professionals have agreed to accept for the same service and the amount the healthcare 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 $2,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. • If two people are covered under your plan, each of you will pay $2,500 ($5,000 total). • If three or more people are covered under your plan, together you will pay $5,000. However, no family member will pay more than $2,500 toward the limit. **When using out-of-network professionals** If you are the only one covered by your plan, you will pay $2,500 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum. • If two people are covered under your plan, each of you will pay $2,500 ($5,000 total). • If three or more people are covered under your plan, together you will pay $5,000. However, no family member will pay more than $2,500 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 • The cost associated with prescription drugs Under the Affordable Care Act, medical and behavioral costs all count toward one combined out of pocket maximum.

Specialist visits do not require PCP referral.

Other benefits may be subject to balance billing, if provided by a non-participating provider.
For more information on balance billing, see page 38 of this enrollment guide.

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Your benefits

HDHP with HSA Plan Summary

Anthem
And Its Affiliate HealthKeepers, Inc.

The HDHP with HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your healthcare. This plan gives you benefits with a high deductible (your upfront out-of-pocket cost) and healthcare dollars to spend your way.

	Your HDHP with HSA plan
First – Use your HSA to pay for covered services: **Health Savings Account** With the HDHP with Health Savings Account (HSA), you can **contribute pre-tax dollars to your HSA**. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.	**Contributions to your HSA*** **The 2022 annual contribution maximum set by the US Treasury and IRS:** $3,650 individual coverage $7,300 family coverage (dependent coverage) **Henrico's 2022 contribution to your HSA**** $1,200 individual coverage $2,400 family coverage (dependent coverage) * These limits apply to all combined contributions from a source including dollars you contribute to your HSA and dollars your employer contributes to your HSA. Rollover funds are not subject to these limits. ** The county's HSA contribution is available to full-time and eligible part-time employees only.
Plus – To help you stay healthy, use: **Preventive care**[1] 100% coverage	**Preventive care** No out-of-pocket costs for you as long as you receive your preventive care from an in-network provider. If you choose to go to an out-of-network provider, your deductible or traditional health coverage benefits will apply.
Then – **your deductible** The deductible is the annual amount you pay – using your HSA or out-of-pocket – before you reach the traditional health coverage portion of the plan.	**Annual deductible responsibility*** $3,000 individual coverage $6,000 family coverage ($3000 individual level) Your benefit period runs on a calendar year from January 1 through December 31. *The deductible includes both medical services and prescription drugs.
If needed – **traditional health coverage** Similar to a PPO or HMO, after you meet your deductible, you pay coinsurance (a percentage of the provider's charges) or a copay when you visit an in-network provider. You'll pay more if you visit an out-of-network provider. Your traditional health coverage begins: 1. Once a family member reaches the individual level deductible (within the annual deductible), that family member's future expenses will be eligible for traditional health coverage. 2. The remaining family members must satisfy the remainder of the annual deductible before traditional health coverage begins.	**traditional health coverage for medical services** After your deductible, the plan pays: 100% for in-network providers — 70% for out-of-network providers **traditional health coverage for prescription drugs** After your deductible, your copay responsibility is: In-network pharmacies: Retail: $10/$30/$55 for 30 day supply — same as in-network pharmacies Mail order: $10/$60/$165 for 90-day supply — n/a
Additional protection: For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the **plan pays 100% of the cost for covered services** for the remainder of the plan year with the exception of: routine vision care, the cost of care received when the benefit limits have been reached, the cost of services and supplies not covered under your benefits, and balance-billed amounts by out of network providers.	**Annual out-of-pocket maximum** In-network providers: $4,000 individual coverage; $8,000 family coverage Out-of-network providers: $6,000 individual coverage; $12,000 family coverage Your annual out-of-pocket maximum consists of your annual deductible and your copay/coinsurance amounts.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal healthcare reform laws. As we receive additional guidance and clarification on the new healthcare 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.

Summary of exclusions or limitations
Other covered services may have limitations or other restrictions.[2] With Anthem's HDHP 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 healthcare 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 two. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorder is unlimited per member per benefit period. Wigs limited to one 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. Other 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 HDHP 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. A 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.

HDHP with HSA 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 HDHP 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

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 a drug until you talk to your doctor.

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HDHP with HSA prescription drug plan *(continued)*

Why generics cost less

Developing a new drug is expensive. When a company creates a new drug, it receives 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 nearly 70,000 pharmacies across the country. That means you have convenient access to your prescriptions wherever you are — at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

To make sure your pharmacy's in our network, visit **anthem.com** and scroll down to the **Manage your Prescriptions** link and log in to access the Pharmacy Overview page.

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

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 receive up to a 90-day supply of medications from a participating retail pharmacy.

**Approximately 98% of the pharmacies in our network participate in the Retail 90 network. 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, log-in to **anthem.com** and select Find a Doctor, which will take you to the list of providers, pharmacies and hospitals who participate in our network.

Note about your pharmacy information on the web:
IngenioRx, an Anthem company, manages the operations of your drug plan.
To access your pharmacy information, go to **anthem.com**.

Home Delivery Pharmacy

Home delivery is for people who take medications on an ongoing basis. The Home Delivery Pharmacy, managed by IngenioRx, 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

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 **anthem.com** to get a **Home Delivery Order Form**.

Mail your completed form, prescription from your doctor for a 90 day supply and payments to:

IngenioRx Home Delivery
PO Box 94467
Palatine, IL 60094-4467

By fax: Have your doctor fax your prescription and plan ID card information to **800-378-0323**. 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 also enroll in Automatic 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 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:

IngenioRx Home Delivery
PO Box 94467
Palatine, IL 60094-4467

Online: Visit **anthem.com**.

Specialty pharmacy

IngenioRx provides support and medicine for people with complex, long-term conditions. They include (but are not limited to) long-term conditions such as inflammatory conditions, diabetes, cancer, HIV, and Hepatitis C.

You don't have to manage your health condition by yourself. Specialty pharmacy experts can help you get the best results from your treatments.

- Pharmacists can tell you more about your condition, how your drugs work, and the side effects. They can also answer urgent drug questions after hours.
- Nurses are available 24/7 to help you stay on track with your medicine. They'll make sure you take it just how the doctor wants. They will also help you with side effects.
- Care coordinators can help answer questions about insurance, paying for your drugs, and getting refills.

continued **»**

HDHP with HSA prescription drug plan *(continued)*

Ordering specialty drugs

You can place your first order by phone or fax:

- **By phone:** Call **833-203-1742**, Monday to Friday, 8 a.m. to 11 p.m. and Saturday 8 a.m. to 5 p.m., Eastern time. A patient care advocate will help you get started.
- **By fax** *(existing medications only)***:** Ask your doctor to fax your prescription and a copy of your ID card to **800-378-0323**.

To order refills online: visit **anthem.com**.

- Scroll down to the **Manage your Prescriptions** link and login to access our Pharmacy Overview page.
- Select the **Specialty Pharmacy Resources** link. You will be directed to the Express Scripts website.
- Select the **Learn More About Specialty Pharmacies** link to access a list of FAQs, including how to start using our exclusive specialty pharmacy.

Drug list

A drug list (or a formulary) is a list of prescription drugs covered by your plan and approved by the US Food and Drug Administration (FDA). It's made up of hundreds of brand and generic drugs.

An independent group of doctors, pharmacists, and other healthcare professionals review new and existing 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.

To view the current list, visit: **anthem.com/pharmacyinformation** and select **National Drug List 3-tier**.

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

Smoking cessation drug coverage

Your plan covers 100% of the cost for certain FDA-approved prescription and over-the-counter (OTC) products to help you quit smoking. You will need to obtain a prescription from your doctor for each product, including OTCs.

When you fill the prescription at a retail pharmacy, you need to show proof that you're at least 18 years old. If you're under 18, you may need to speak with your doctor to receive the OTC product. By law, they can only be sold to people over 18.

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 OTC™)
- Cetirizine (generic equivalents of Zyrtec OTC®)
- Fexofenadine (generic equivalents of Allegra OTC®)
- Loratadine (generic equivalents of Claritin OTC®)
- Alaway™
- Zaditor®
- Miralax OTC®

The following OTC items are also 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 six 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, other 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 Member Services phone number on your HDHP HSA plan ID plan card.

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

Tips for understanding your coverage

Knowing the plan you have selected can make all the difference in getting the most value from your Anthem HealthKeepers coverage. Here are tips to keep in mind when seeking services.

Services that require advance reviews

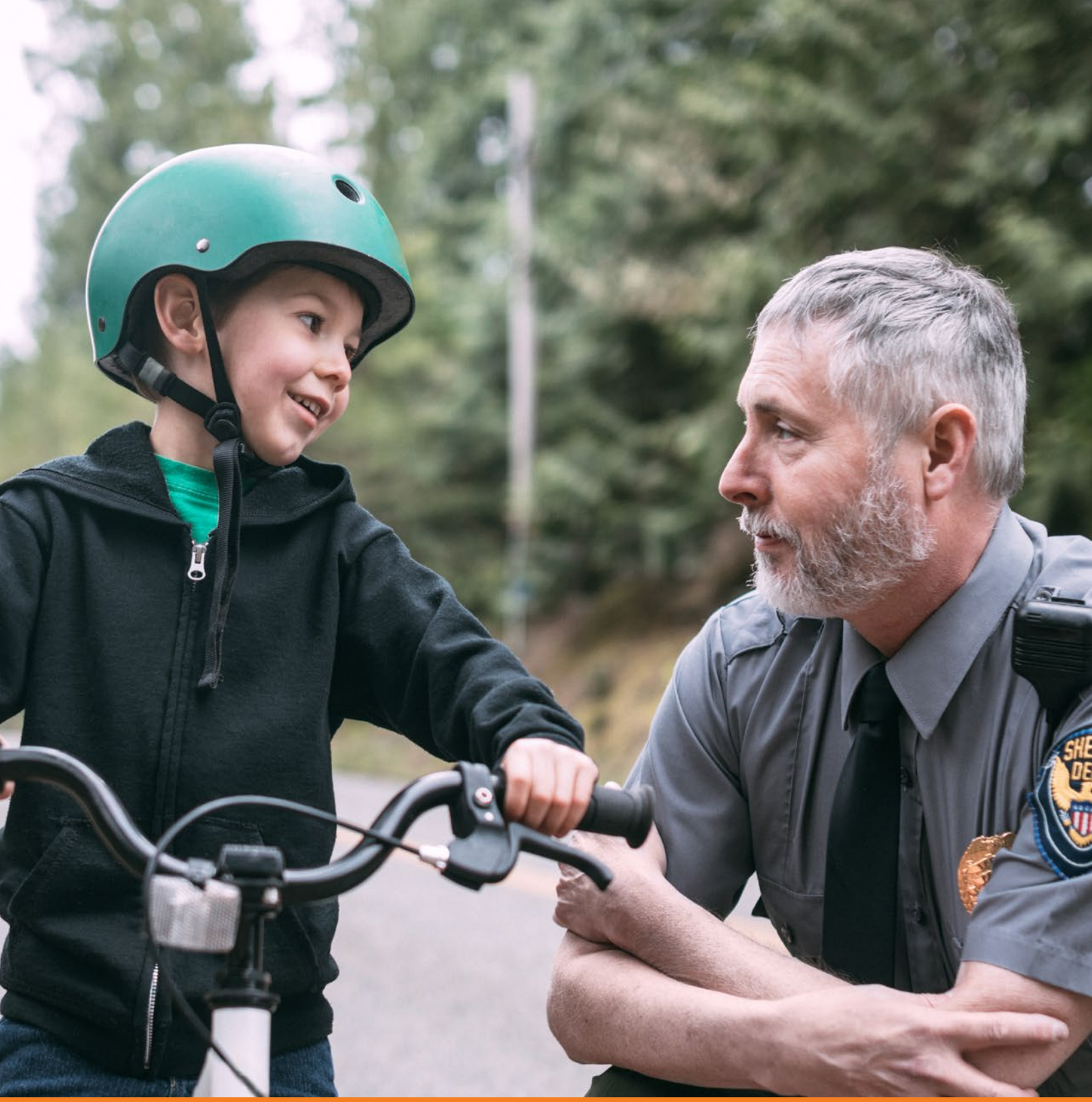
While you can see a doctor or go to a hospital in your plan's network, there may be instances in which a test or procedure your doctor wants you to have may not be covered. To help you minimize unanticipated costs from a non-covered service, we work with our in-network providers to make sure that certain 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 receive prior authorization for a medical service, if required.



Ins and outs of coverage

The ins and outs of coverage

Knowing that you have healthcare 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 your family, including:

- 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.

Certain 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:

Renewed	Cancelled	When ...
●		You maintain your eligibility for coverage with your employer, pay your required portion of the healthcare 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.

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. There may be instances 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). 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). 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. 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.

continued **»**

The ins and outs of coverage *(continued)*

When you're covered by multiple plans

If you're covered by more than one health plan, our Coordination of Benefits (COB) program helps ensure you receive the benefits due and avoid overpayment by either carrier. 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 remaining benefits.

Special Note for HDHP HSA plan

The IRS and US 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 a health Flexible Spending Account
- Enrolled in Medicare, TRICARE, or TRICARE for Life
- Claimed as a dependent on someone else's tax return
- Received Veterans Affairs (VA) benefits within the past three months, except for preventive care. If you have a disability rating from the VA, this exclusion does not apply

How benefits apply when Medicare-eligible

Certain people under age 65 are eligible for Medicare in addition to 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 less than 100 participants		●

When a person is covered by Medicare and a group plan, and	Then	Anthem HealthKeepers	Medicare is primary
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 less 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 healthcare 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 overpayment from:

- A person to or for whom the overpayments were made;
- A healthcare company; and
- Another organization.

What's not covered (exclusions)

When it comes to your health, you're the final decision maker about what services you need to recieve and where you should get them from. To keep the cost of healthcare 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 for 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

continued »

The ins and outs of coverage *(continued)*

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.

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 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
- Services or supplies provided to a person not covered under these plans 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 drugs, procedures, or healthcare 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 healthcare 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 potential risks;
- At least the same or better effectiveness as a 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.

continued **»**

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 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 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

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 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 two 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 eight 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 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 a 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.

continued **»**

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 a 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 (applies to HDHP with HSA plan only)

- Over-the-counter drugs (except as noted within the prescription drug benefits section of this enrollment book)
- A 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
- A 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 another drug or medical service
- Mail-order providers other than our home delivery mail-order provider. Prescription drugs dispensed by a 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
- Delivery charges for the delivery of prescription drugs

- Weight loss drugs
- Drugs not approved by the FDA
- 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 a similar program authorized by state or local laws or regulations or 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 US 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 healthcare 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

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

continued **»**

The ins and outs of coverage *(continued)*

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)

- A 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 self-help physical exercise training
- A related diagnostic training
- Air conditioners, air purifiers, therapeutic mattresses, supplied, or similar devices or appliances
- Vitamins, mineral, nutritional supplements, or 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 three who qualify for early intervention services
- Group speech therapy
- Group or individual exercise classes or personal training sessions
- Recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

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

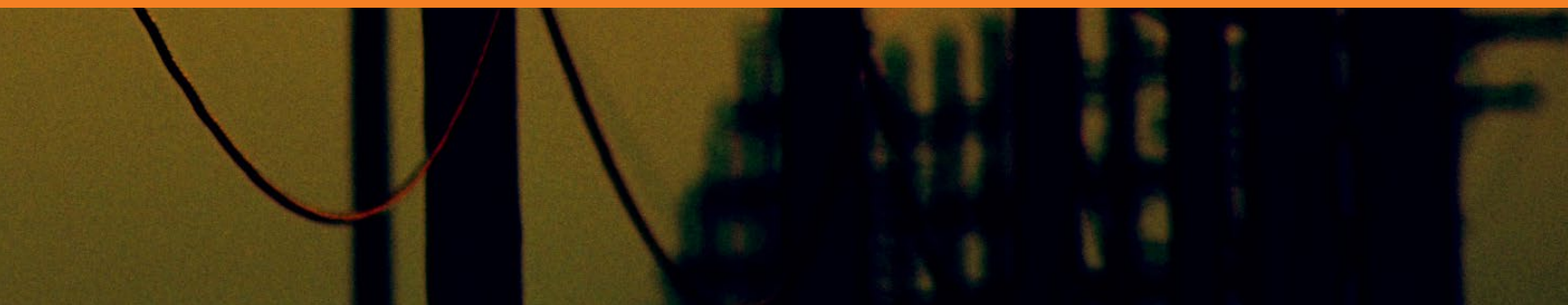
Vision services (except as provided through Blue View Vision)

- 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
- Non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- 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 government entity
- 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.

Additional benefits



Blue View Vision℠

Vision care is not just for eyeglass wearers. Routine eye visits are important for everyone in preventing eyesight damage. Eye exams can also help detect other health problems. Blue View Vision exists so you can receive the vision care you need while still staying on 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, and Pearle Vision® are covered by the plan. You can find a Blue View Vision network provider at **anthem.com**.
- **You can get an eye exam every year.** Blue View Vision helps pay for eye exams annually.
- **Not many plans are this convenient.** 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.** If you want a frame that costs more than your plan allows, you can save 20% off the balance. If you want spare glasses, contact lenses, or prescription sunglasses, you can save 15 to 40%. 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.

Blue View Vision℠ exam only A15 plan

Anthem
And Its Affiliate HealthKeepers, Inc.

WELCOME TO BLUE VIEW VISION

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

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®, Target Optical®, and most Pearle Vision® locations. When you receive 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

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 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 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

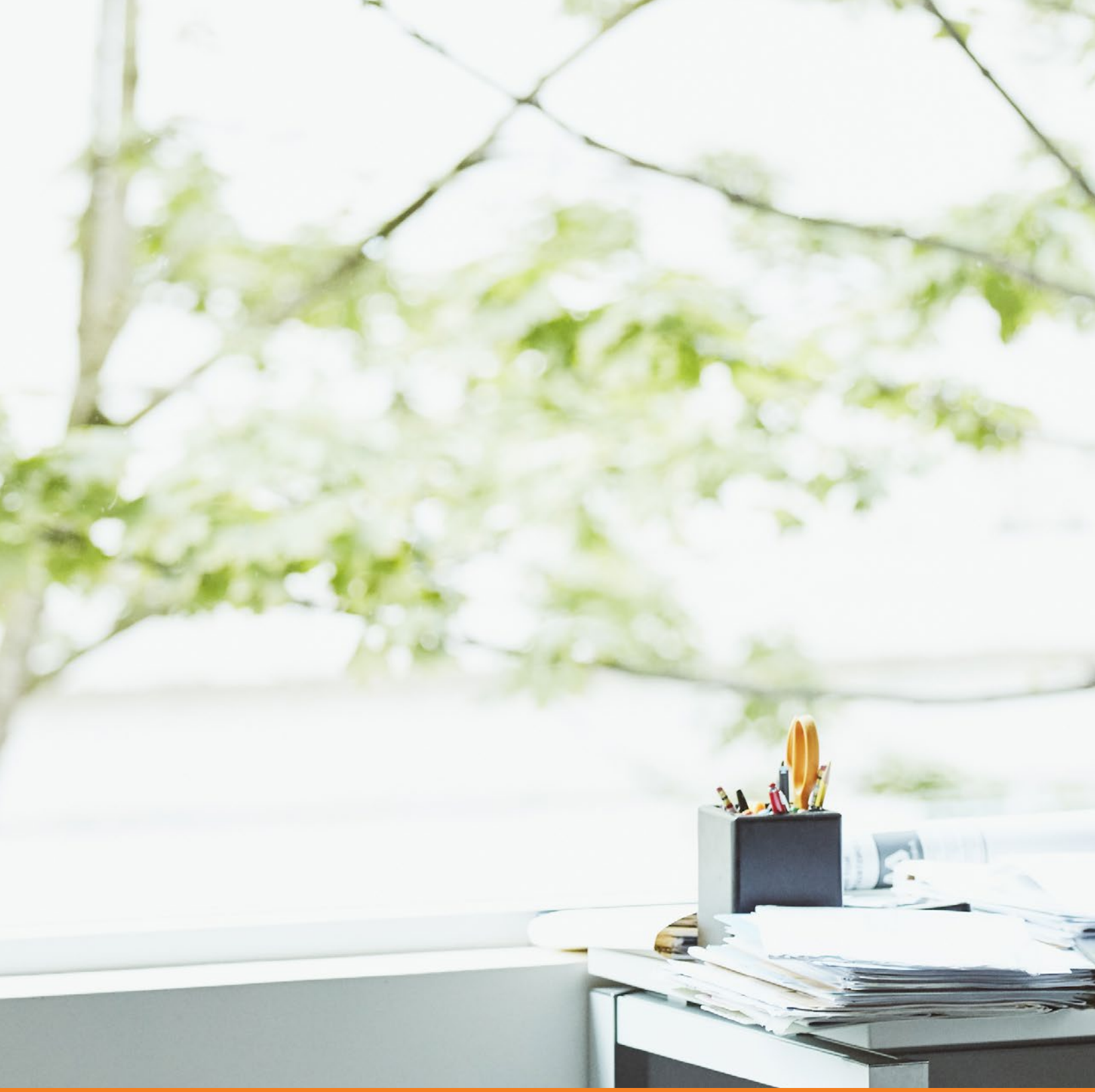
This is a primary vision care benefit and is intended to cover only eye examinations. If medical treatment of the eyes is needed, you should visit a participating eye care physician from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage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

Combined offers. Not combined with other offer, coupon, or in-store advertisement.
Experimental or investigative. Any experimental or investigative services.
Uninsured. Services received before insured person's effective date or after coverage ends.
Excess amounts. Amounts in excess of covered vision expense.
Eyewear. A type of eyewear and related materials including eyeglass lenses, frames, or contact lenses.
Routine exams or tests. Routine examinations required by an employer in connection with insured person's employment.
Work-related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under workers' compensation, employer's liability law or occupational disease law, even if insured person does not claim those benefits.
Government treatment. 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.
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.
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.
Not specifically listed. Services not specifically listed in this plan as covered services.
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.
Eye surgery. Medical or surgical treatment of the eyes and diagnostic testing. 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.
Hospital care. Inpatient or outpatient hospital vision care.
Orthoptics. Orthoptics or vision training and associated supplemental testing.
Crime or nuclear energy. Conditions that result from: (1) insured person's commission of or attempt to commit a felony; or (2) release of nuclear energy, whether or not the result of war, when government funds are available.

1 A 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.

2 A 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 certain 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.



Health, wellness and Anthem advantages

Make the most of your health plan

anthem.com

Clear. Intuitive. Convenient.

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. Visit **anthem.com** and login to your account to have access to an array of innovative tools to help you manage your health and achieve your goals.

Health 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 healthcare 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 the Health Assessment:

- Select **Health & Wellness**
- Under Health Assessment, select **Take my HA now**

Health 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, and medical conditions. Print and share with your doctors to help avoid potential drug interactions and duplicative tests and procedures.

To use the Health Record:

- Log in at **anthem.com**
- Select **Health & Wellness**
- 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. 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
- HDHP — $59 fee (this goes toward your deductible if you haven't met it)

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

LiveHealth Online Psychology
A convenient way to see a therapist or psychologist.

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 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 convenient 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 **844-784-8409** from 7 a.m. to 11 p.m. You'll receive an email confirming your appointment.
- You pay the following:
  - Premier Plan — $10
  - Standard Plan — $15
  - HDHP — 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, and weight loss programs.

To access all discounts:

- Log in at **anthem.com**
- Select the **Discounts** tab

Patient Ratings & Reviews
Doctor recommendations from your peers

Choosing a doctor is one of the most important choices you make for your healthcare. 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 **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 anthem.com? Sign up now for access to personalized service and resources. It's fast, convenient, 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 **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. 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 healthcare decisions you need to make, whenever you need to make them. 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. It can also safeguard your health and the health of your family.

To reach 24/7 NurseLine, call 800-337-4770.

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 866-664-5404.

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. They work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure, and coronary artery disease. With ConditionCare, you'll receive 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, call 800-445-7922.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

MyHealth Advantage connects your claims, doctor reports, personal health history, and other information for a bigger picture of your health. If we see things you can act on to help improve your health or save money, you'll get a MyHealth Note — a confidential health summary. The program can help you keep health issues from developing or becoming serious. That means lower healthcare costs down the road.

MyHealth Notes are mailed to you, or you can read our suggestions on your iPhone or Android device by downloading the Anthem Sydney app. With this app, you have the option of receiving personalized health messages on the go via the Secure Message Center.

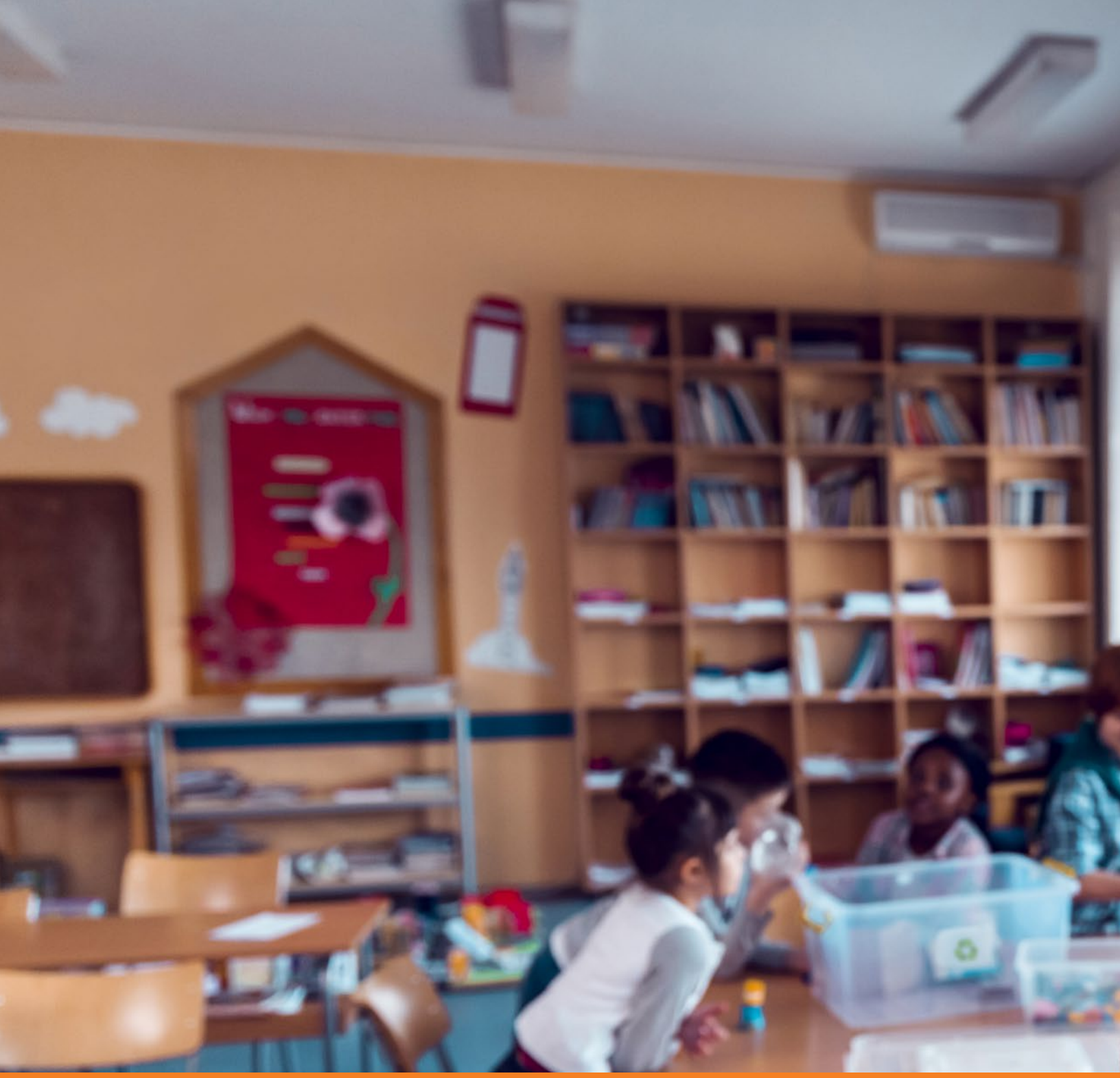
Healthy Lifestyles

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 helps you 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
- Receive discounts on massages, gym memberships, and spa services

To learn more, visit 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 (such as surgery, a treatment done in a doctor's office, or physical therapy) 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 healthcare 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 healthcare 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 another type of service or treatment.

Other types of medical needs you may have that might call for a prospective review include:

- To go to (and/or stay at) a hospital
- An outpatient procedure (you 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, and hospital beds

The concurrent review (done during medical care and recovery)
A concurrent review is done at the time you are in the hospital or released and need 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 healthcare, durable medical equipment (see above), staying in a nursing home, and receiving emotional healthcare. The UM review team looks at your medical information at the time of the review to see if the treatment is medically needed.

The retrospective or post-service review (done after medical care is given)
A retrospective review is done when you have already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at your 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 healthcare 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. Knowing these rights and responsibilities helps you know what you can expect from your overall healthcare experience and become a smarter healthcare consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all healthcare 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 healthcare.
- 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.
- Receive information about our company, services, network of doctors, and other healthcare providers.
- Receive more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about the rules of your healthcare plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your healthcare plan
  - Care you receive
  - Covered service or benefit ruling that your healthcare plan makes
- Say no to care, for a condition, sickness, or disease, without it affecting the 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.
- Receive 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 healthcare 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.

You have the responsibility to:

- Keep all scheduled appointments with your healthcare 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 healthcare professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or healthcare professionals.
- Tell your doctors or other healthcare professionals if you don't understand the care you're receiving or what they want you to do as part of your care plan.
- Follow all healthcare plan rules and policies.
- Let our Member Services department know if you have changes to your name, address or family members covered under your plan.
- Give us, your doctors and other healthcare professionals the information needed to help you receive the best possible care and all the benefits you are entitled to. This may include information about other healthcare plans and insurance benefits you have in addition to your coverage with us.

Let Henrico General Government or Public Schools know if you have changes to your name or address, or if your covered dependents are no longer eligible for coverage (such as a 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.

If you ever need a benefit-covered mastectomy, we hope it will give you 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. 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 healthcare you get through your plan. We keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For healthcare operations: We use and share PHI for our healthcare operations. 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 healthcare provider such as your doctor or a hospital. We may share PHI with your healthcare 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 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. 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 US 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 a other purpose not stated in this notice. You may take away this OK, in writing. We will then stop using your PHI for that purpose. If we have already used or shared your PHI based on your OK, we cannot undo 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.

continued **»**

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

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 healthcare 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. You can 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.

Call Member Services at the phone number printed on your ID card to use these rights. They can give you the address to send the request. They can also give you 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. Other 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 a 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 US 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. Even if you have agreed to receive 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 PHI we may receive 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 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 changes.

continued **»**

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

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 other 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 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, finding answers to your questions is quick and convenient.

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

Anthem®
And Its Affiliate HealthKeepers, Inc.

County of Henrico
General Government

HCPS
Henrico County Public Schools

The most detailed description of benefits, exclusions and restrictions can be found in the Plan Document for County of Henrico Health Plan. If you have questions, please contact your Benefits Office or Member Services.

This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there are differences 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 833-630-6742. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031.

Visit us online at **anthem.com**

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